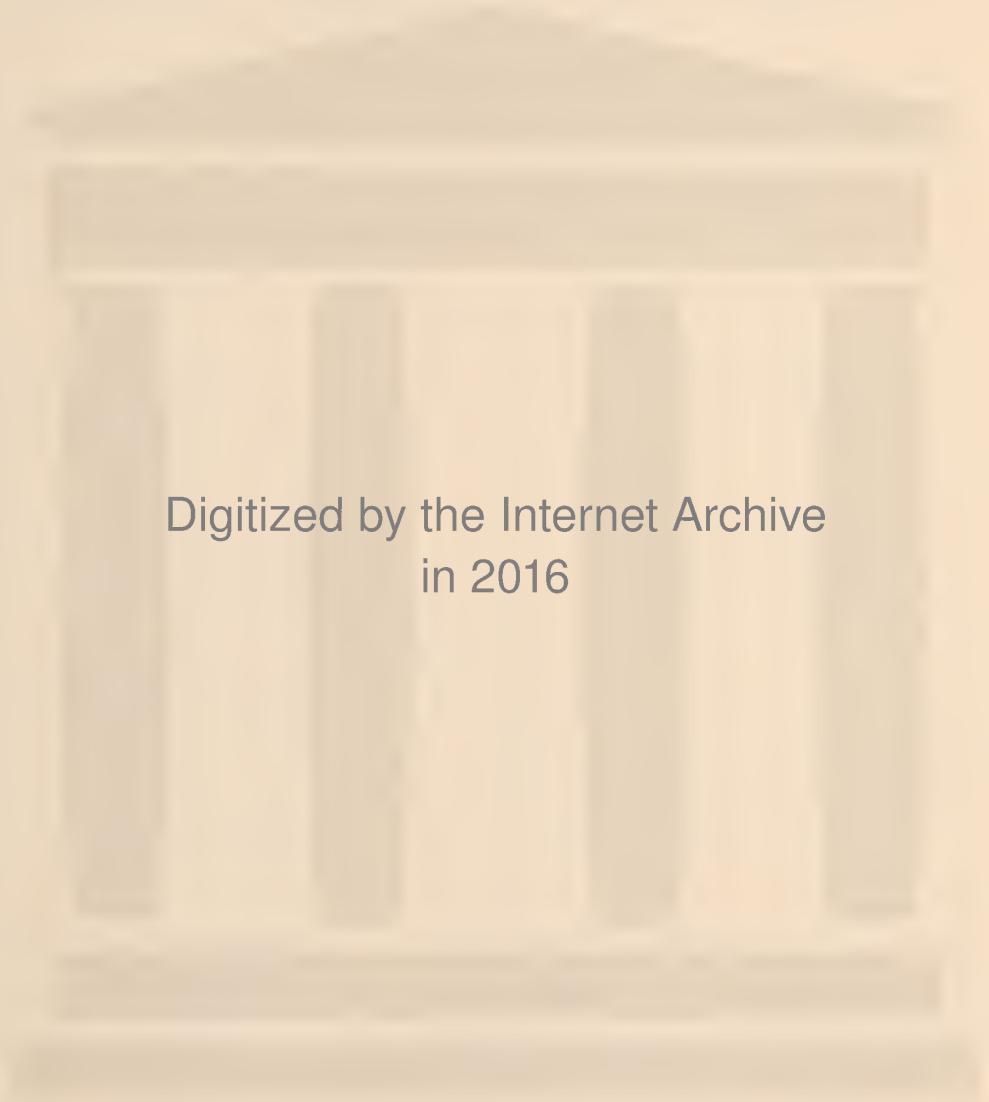
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THE JOURNAL

OF

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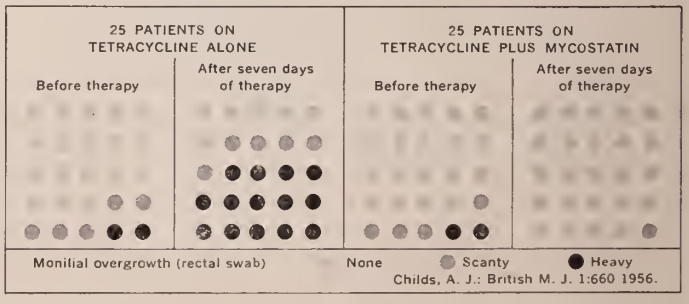
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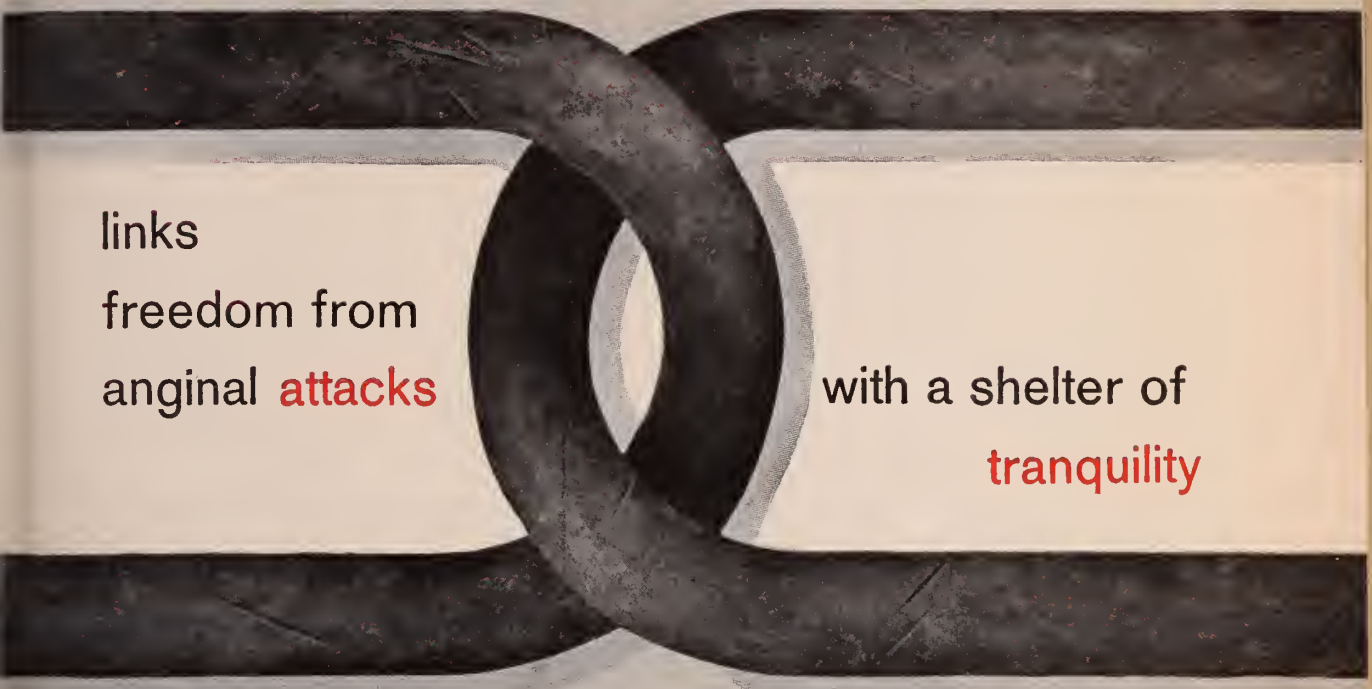
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1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.



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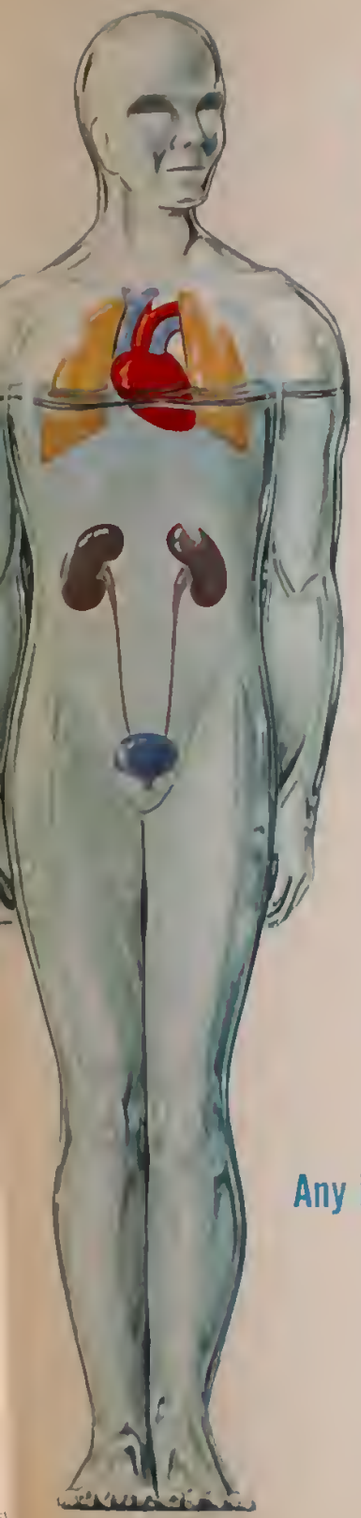
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References

1. Hollander, William, and Wilkins, Robert W.: Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension, Boston Medical Quarterly *8*:69 (Sept.) 1957.

2. Freis, Edward D., and Wilson, Ilse M.: Potentiating Effect of Chlorothiazide (DIURIL) in Combination with Antihypertensive Agents, a Preliminary Report; Med. Annals of the District of Columbia *26*:468 (Sept.) 1957.

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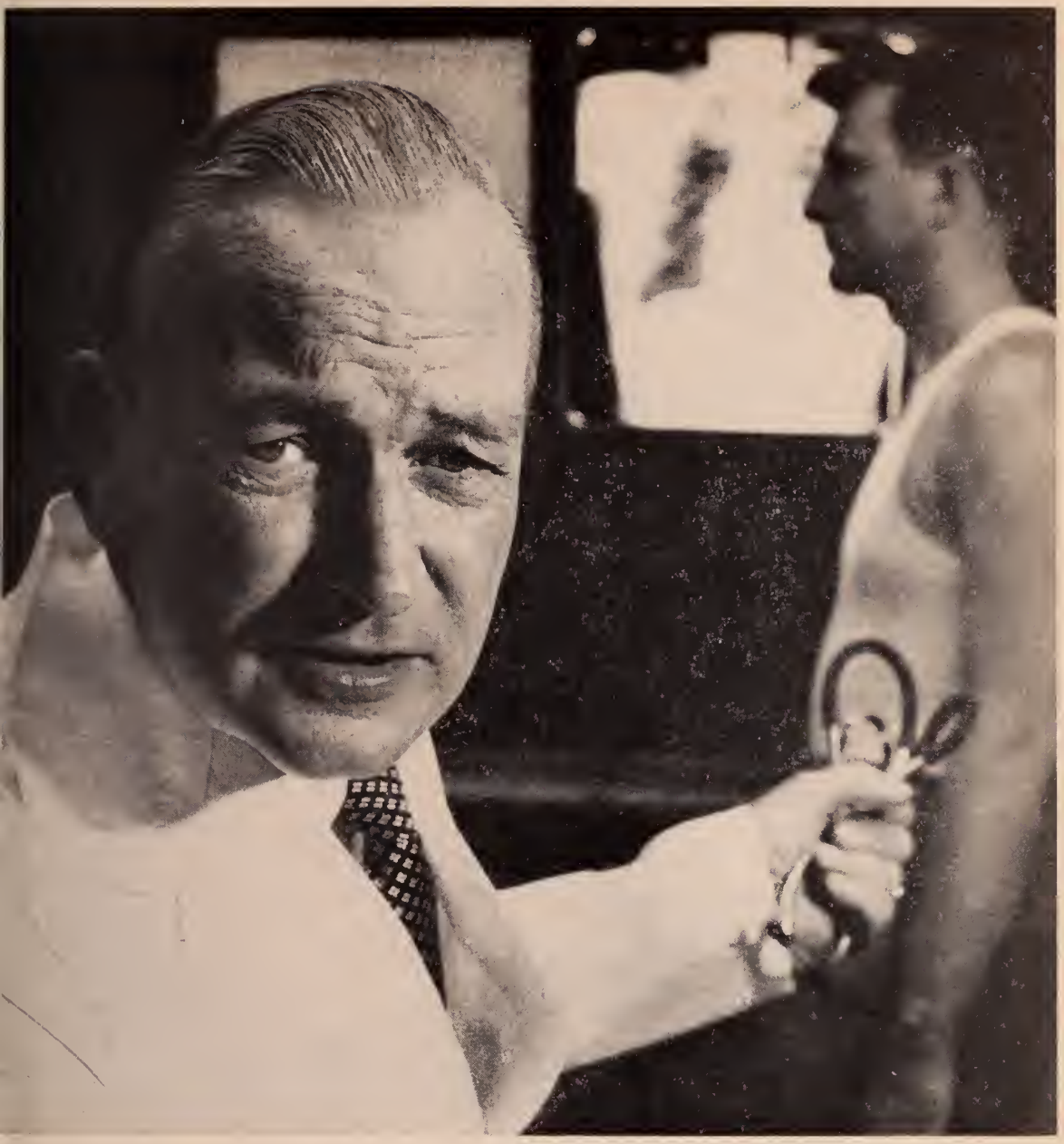
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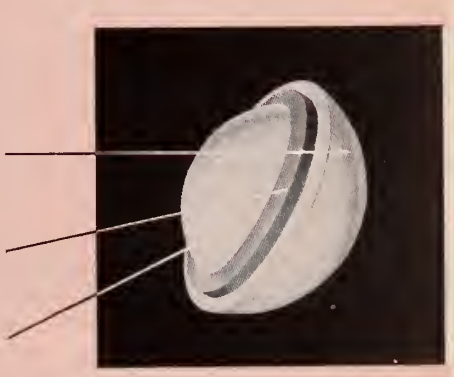
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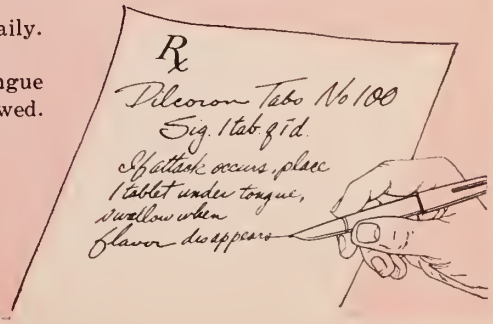


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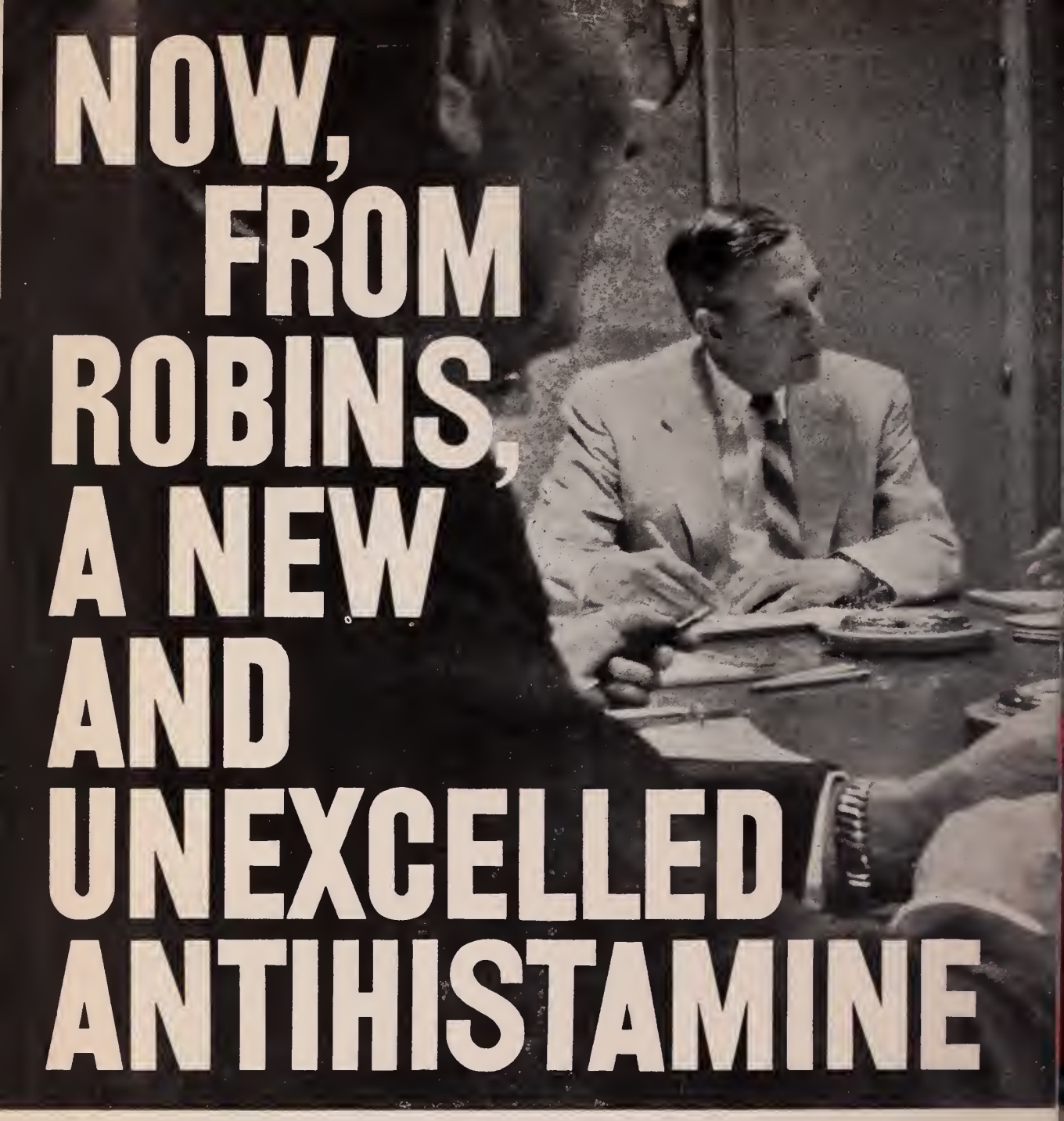
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Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsine
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1)

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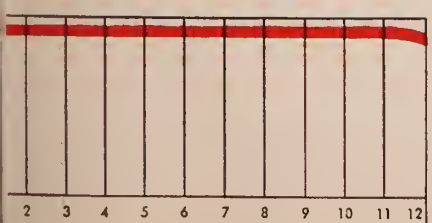
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Bristol
LABORATORIES INC
SYRACUSE, NEW YORK

24-hour blood levels

on a **SINGLE** intramuscular dose, in minimal injection volume

This achievement is made possible by the unique solubility of TETREX (tetracycline phosphate complex), which permits *more* antibiotic to be incorporated in *less* volume of diluent. Clinical studies have shown that injections are well tolerated, with no more pain on injection than with previous, less concentrated formulations.

TETREX Intramuscular '250' can be reconstituted for injection by adding 1.6 cc. of sterile distilled water or normal saline, to make a total injection volume of 2.0 cc. When the entire 250 mg. are to be injected, and minimal volume is desired, as little as 1.0 cc. of diluent need be used. (Full instructions for administration and dosage for adults and children, accompany packaged vial.)

Each one-dose vial of TETREX Intramuscular '250' contains:

TETREX (tetracycline phosphate complex) (tetracycline HCl activity).....**250 mg.**

Xylocaine* hydrochloride ..... **40 mg.**

plus ascorbic acid 300 mg. and magnesium chloride 46 mg. as buffering agents.

**® of Astra Pharm. Prod. Inc. for lidocaine*

SUPPLY: Single-dose vials containing TETREX – tetracycline phosphate complex – each equivalent to 250 mg. tetracycline HCl activity. Also available in 100-mg. single-dose vials.

NTRAMUSCULAR '250' WITH XYLOCAINE

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PRINCETON HOSPITAL'S modern approach to long-term nursing care

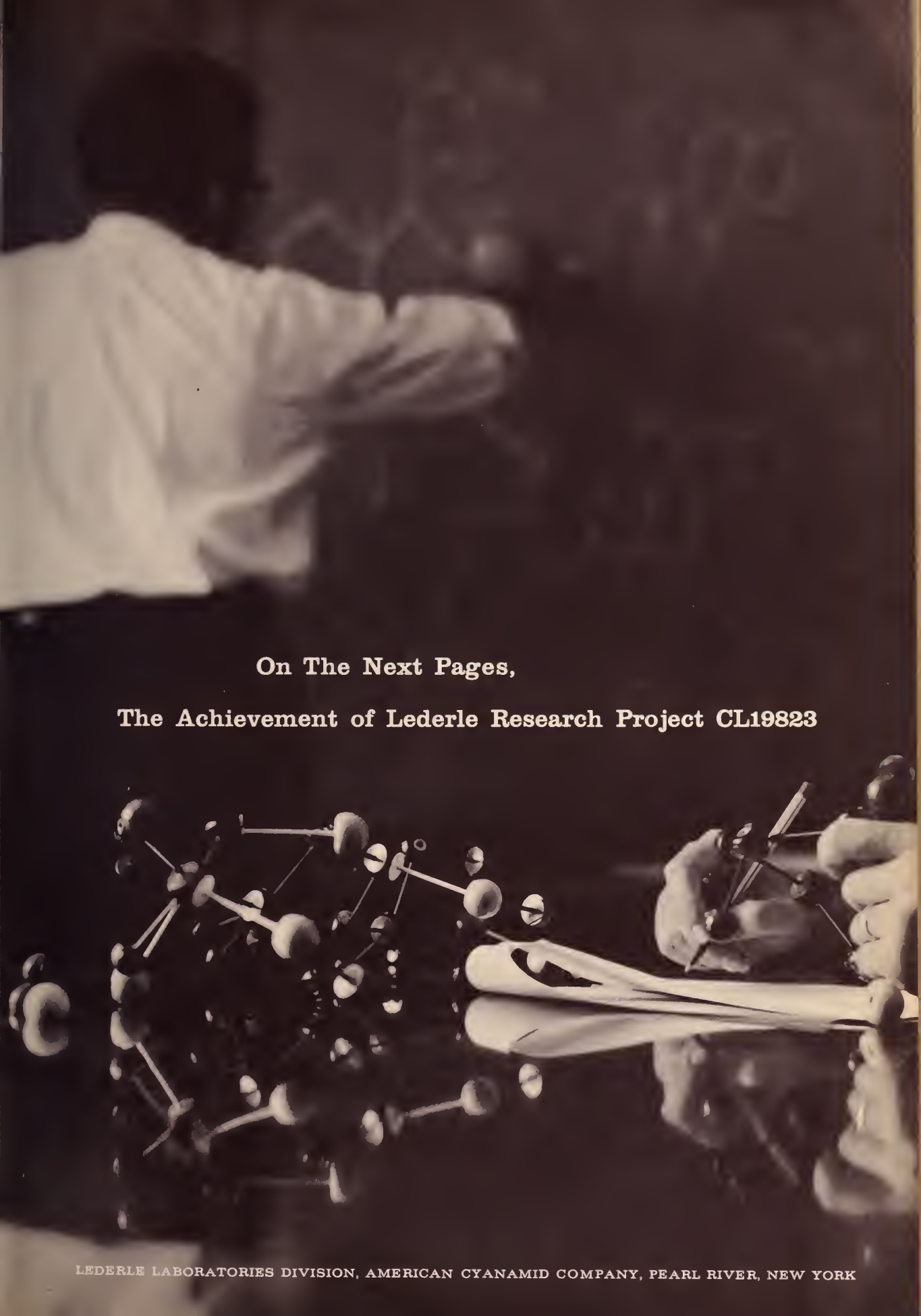
Merwick, the Elsie Procter Matthews Unit of Princeton Hospital, is a pioneer medical undertaking in the state of New Jersey. Designed specifically for geriatric cases and the chronically ill of all ages (except pediatric cases), it is the first long-term nursing facility in the State directly operated by a general hospital.

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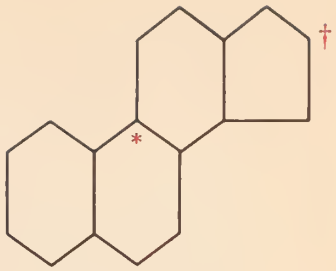
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Lederle announces a major drug with great new promise

Arist

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major deterrents to all previous steroid therapy



ocort®

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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Lower incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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Lederle

The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are below compared to the reported incidence of those from prednisone and prednisolone.

Peptic Ulcer

The most recent study available on the incidence of peptic ulceration in patients with rheumatoid arthritis on long-term prednisone therapy reported 12 ulcers in 49 cases (24 per cent).[1] Lowest incidence of 6.5 per cent has been recorded in a group of patients on this drug for six to nine months.[2] Four of six ulcers, in another series of 39 patients on prednisone,[3] appeared in less than three months of therapy.

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

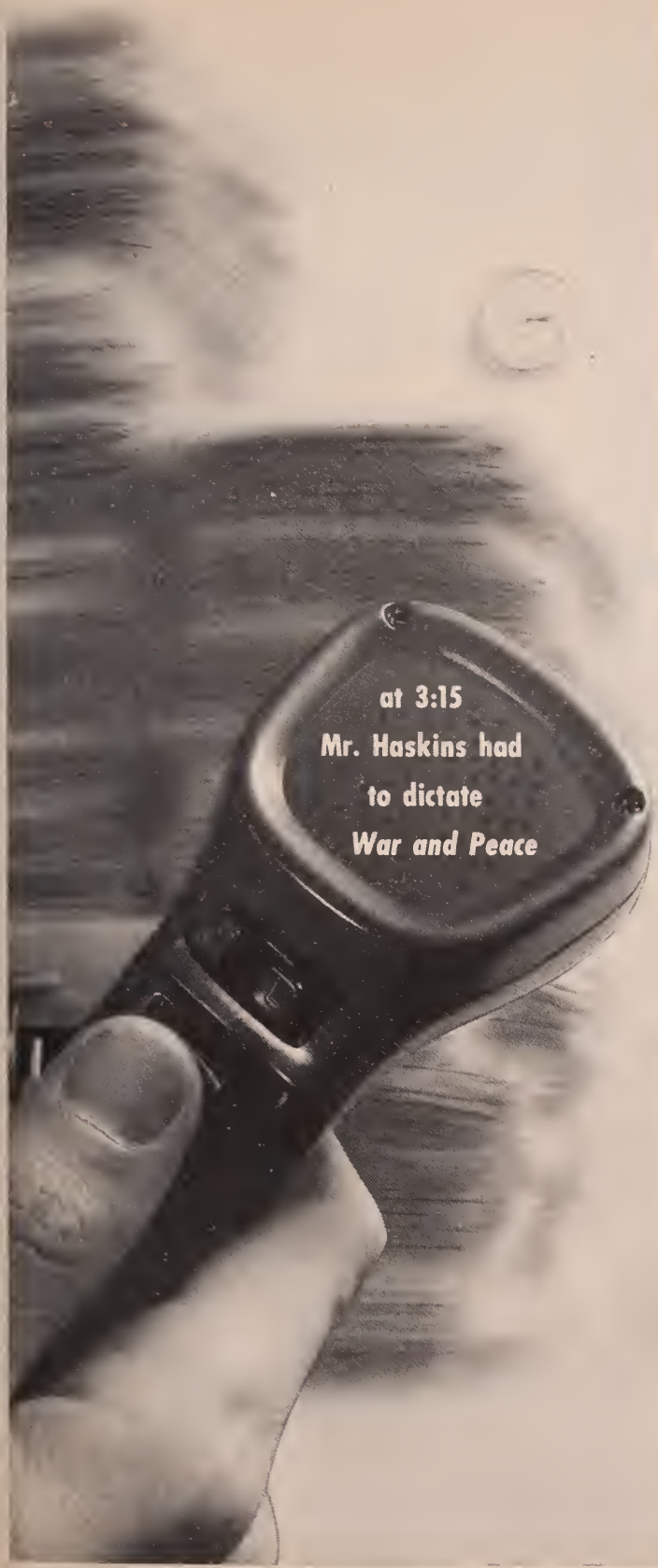
The incidence of compressed fractures of vertebrae—and to a lesser extent in other bones—is high in patients on prolonged therapy with all previous corticosteroids.[4] One group of 49 patients[1] on long-term prednisone treatment experienced nine vertebral fractures (18 per cent); another series of 39 developed eight fractures (20 per cent),[3] four to 15 months after the beginning of steroid administration.

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[5]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[4] and toxic syndromes producing even convulsions and death.[6]

Since the onset of these complications is not directly related to duration of steroid administration,[7] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.



To cut daytime lethargy

(and keep rauwolfia potency)

in treatment

of hypertension:

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Reviews of ataraxic therapy commonly divide the available tranquilizers into three main categories: the rauwolfia derivatives; the phenothiazine compounds; and a smaller group of agents which are lumped together for the sake of convenience rather than because of any common characteristic.

As a result, one significant fact is often overlooked: ATARAX (hydroxyzine) does not fit into any of these three categories. Indeed, by any logical criterion, it belongs in a class by itself.

1. ATARAX is chemically unique. It differs from any other tranquilizer now available, not in minor molecular rearrangements but in basic structure.

2. ATARAX is therapeutically different. ATARAX is characterized by unique cerebral specificity. On ATARAX, the patient retains full consciousness of incoming stimuli —their nature and their intensity—but his reactions are those of a well-adjusted person. He is neither depressed nor torpid, and his reflexes remain normal, as does cortical function. Thus ATARAX induces a calming peace-of-mind effect without disturbing mental alertness.

3. ATARAX is, perhaps, the safest ataraxic known. It is outstandingly well tolerated. Every clinical report confirms this fact.* After more than 150 million doses, there has not been a single report of toxicity, blood dyscrasia, parkinsonian effect, liver damage, or habituation.

4. ATARAX is unusually flexible. This lack of toxicity makes it possible to adjust ATARAX dosage to virtually any patient need. In the lowest range, children respond well to 10 mg. or one teaspoonful of syrup t.i.d., while anxious adults usually are treated with 25 mg. q.i.d. Yet, if needed, the dosage can safely be raised: in more severe disturbances, dosages up to 1,000 mg. daily have been administered without adverse reactions.

In reviewing your own experience with tranquilizers, remember that ATARAX is in a class by itself; that you cannot judge it by your results with any other drug. To get to know ATARAX at first hand, prescribe it for the next four weeks whenever a tranquilizer is indicated. See for yourself how it compares.

*Documentation on request

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Bottle of 24 tablets

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ACHROMYCIN ® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
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Pyrilamine Maleate	15 mg.
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The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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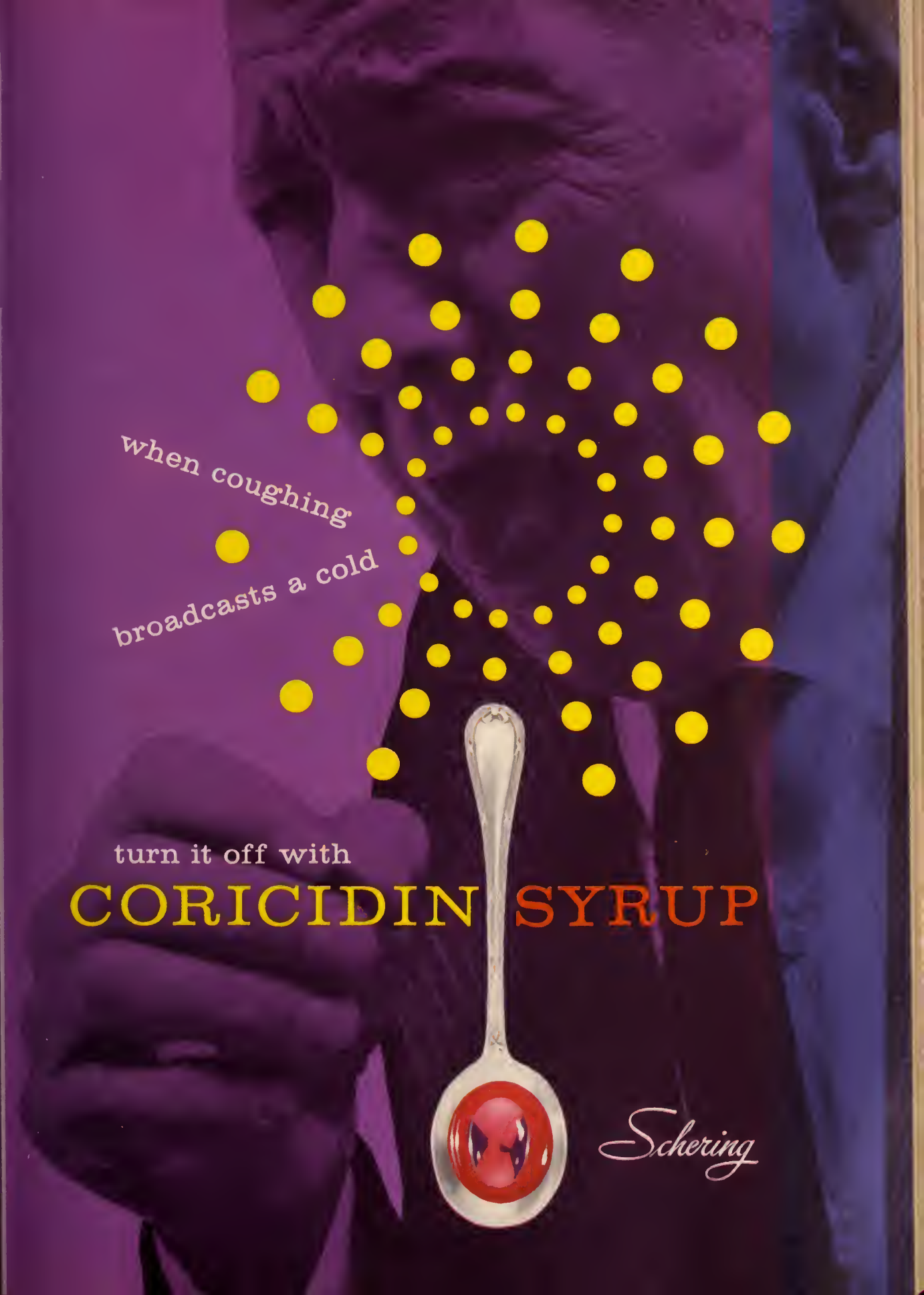
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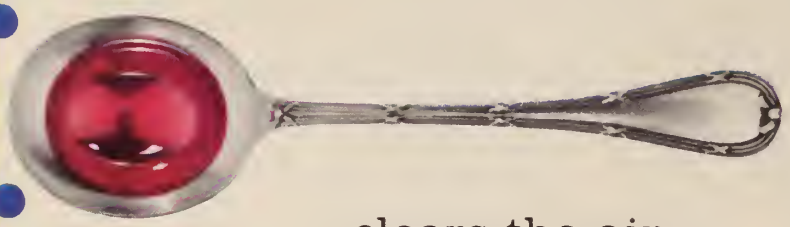
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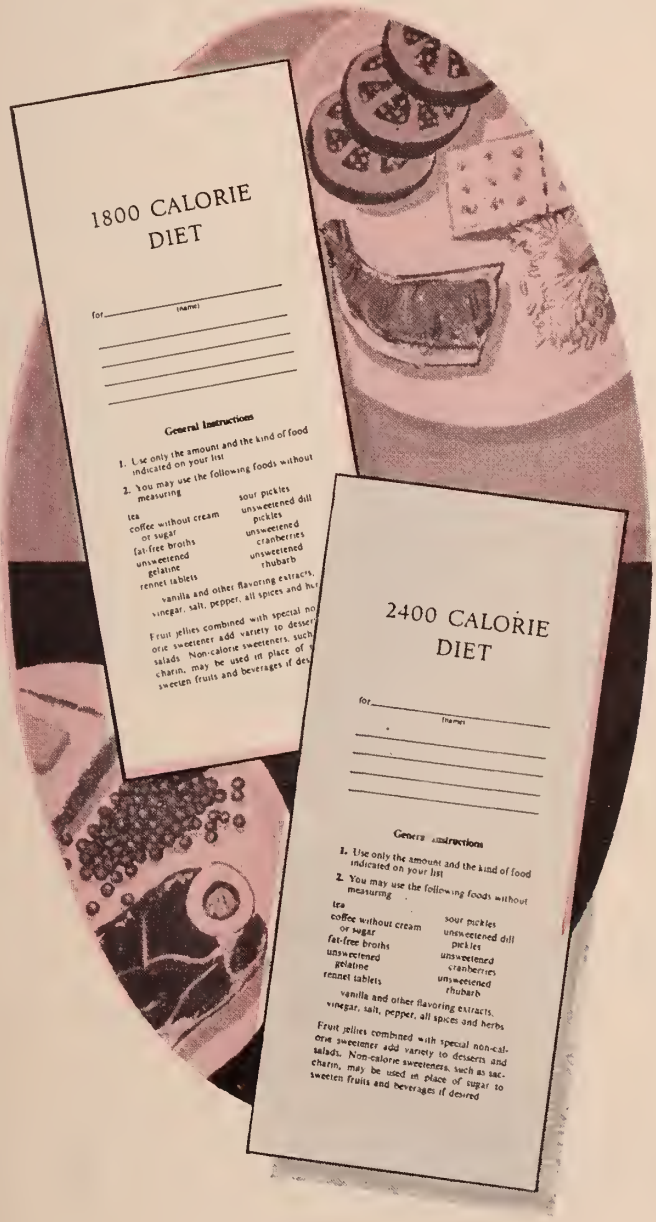
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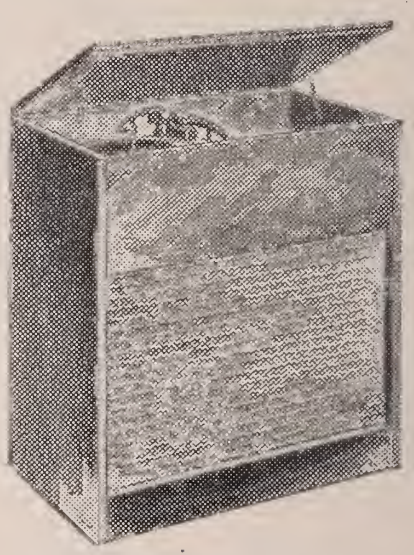
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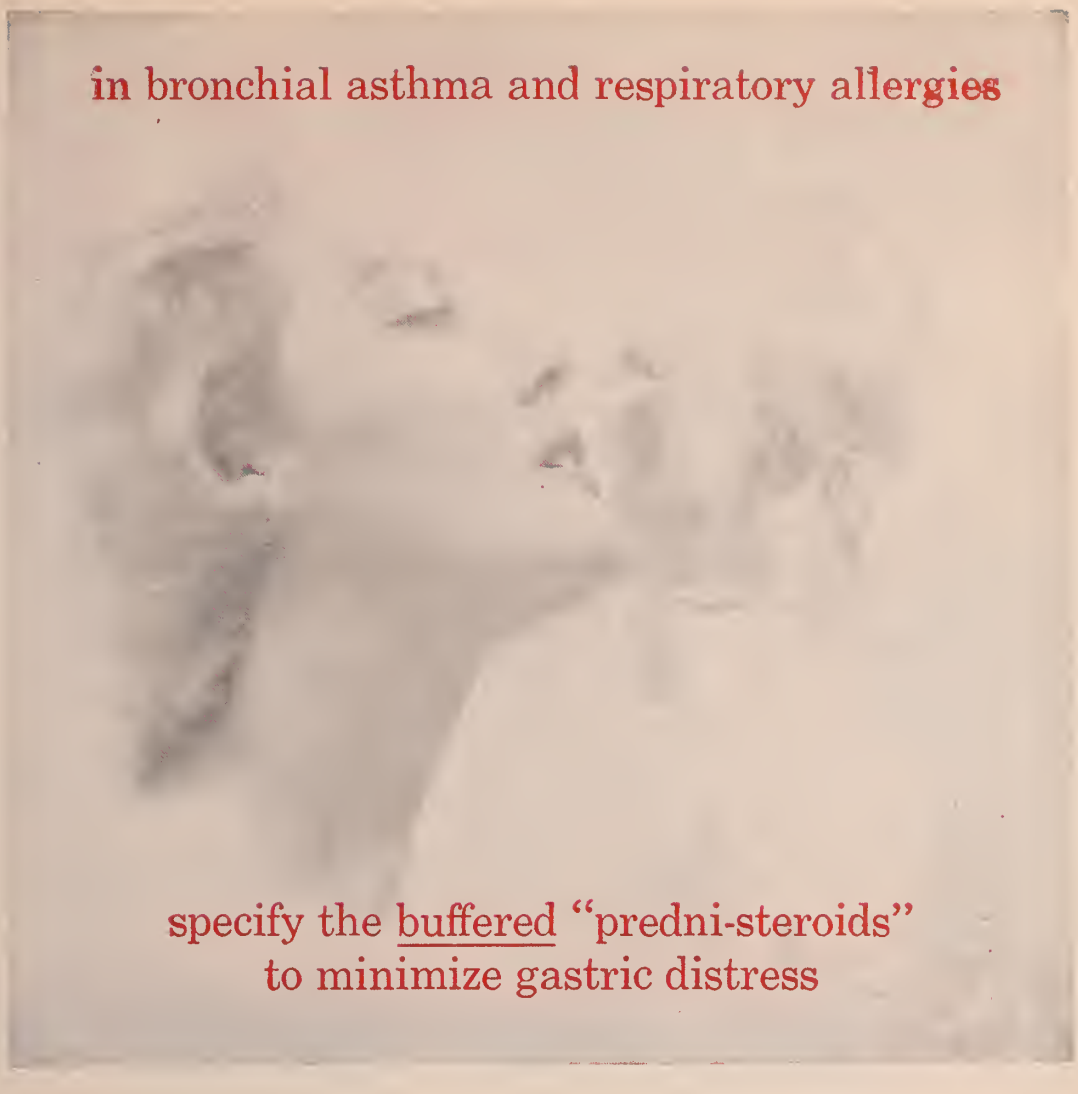
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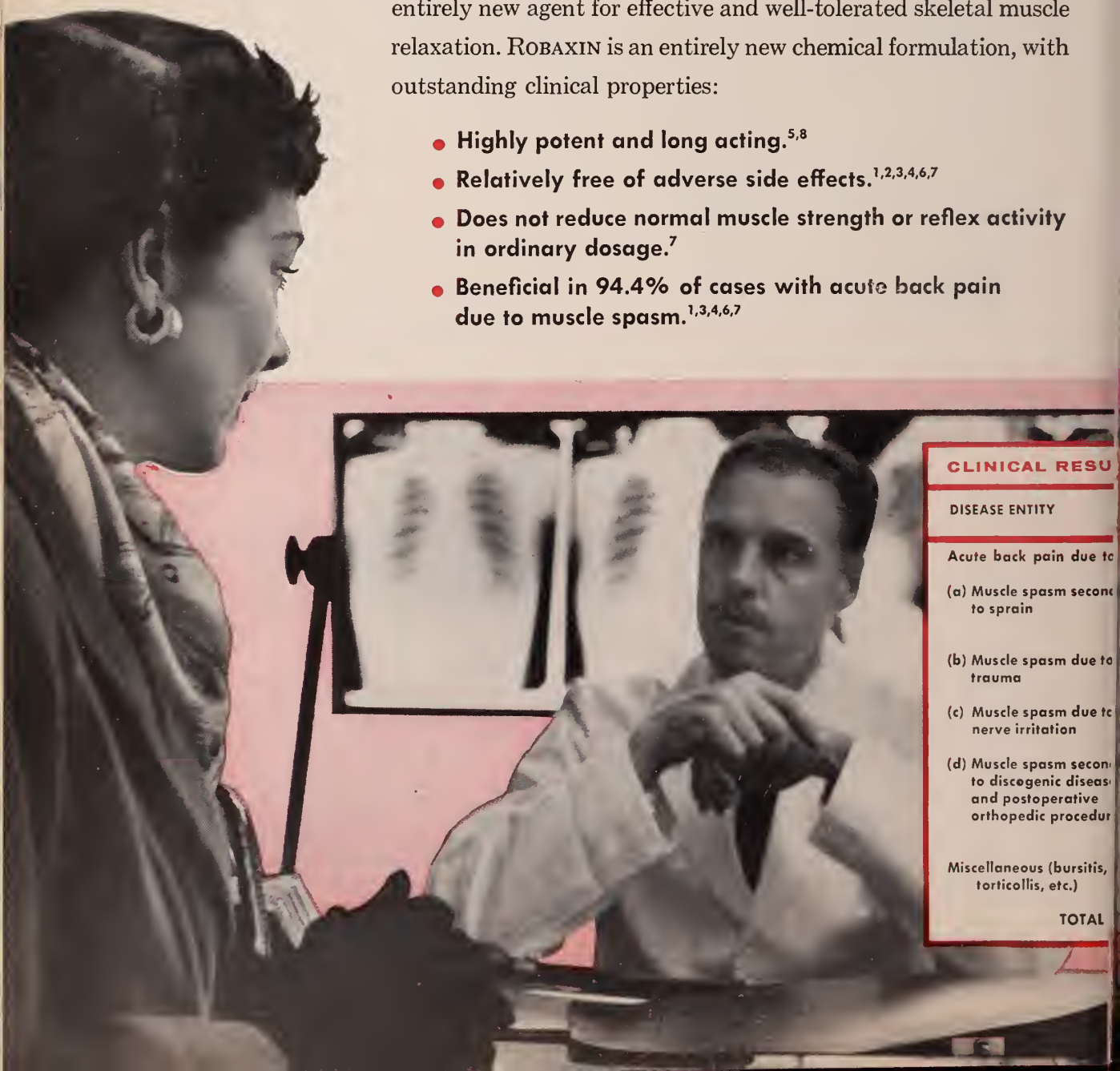
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- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RESU	
DISEASE ENTITY	
Acute back pain due to	
(a) Muscle spasm secon to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm secon to discogenic diseas and postoperative orthopedic procedur	
Miscellaneous (bursitis, torticollis, etc.)	
TOTAL	



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TH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

F	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
	3-60 days	4-8 Gm.	6	0	0	0	None, 6
			59	6	3	4	*Relieved on reduction of dose

References: **1.** Carpenter, E. B.: Publication pending. **2.** Carter, C. H.: Personal communication. **3.** Forsyth, H. F.: Publication pending. **4.** Freund, J.: Personal communication. **5.** Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. **6.** Nachman, H. M.: Personal communication. **7.** O'Doherty, D.: Publication pending. **8.** Truitt, E. B., Jr., and

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

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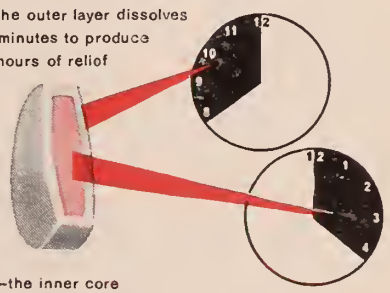
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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REFERENCES: 1. Rives, H. F.: Texas J. M. **52**:224, 1956. 2. Diggs, E. S.; Prevost, E. C., and Valderas, J. G.: Am. J. Obst. **71**:399, 1956. 3. MacLead, P. F., et al.: Internat. Rec. Med. **169**:561, 1956.

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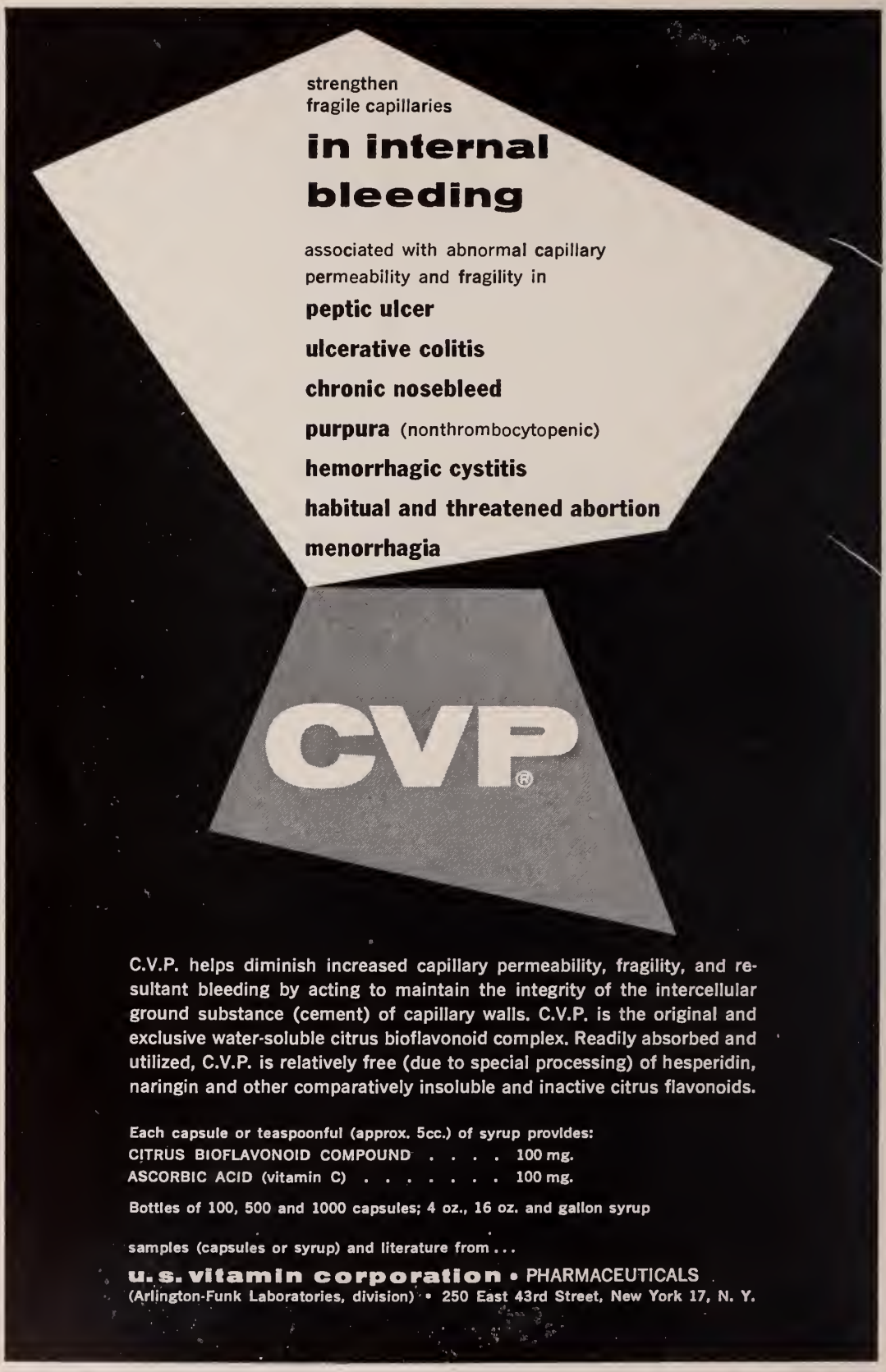
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†Ayd, F. J., Jr.: The Treatment of Ambulatory and Hospitalized Psychiatric Patients with Trilafon, presented at Ann. Meet., Am. Psychiat. Assoc., Chicago, Ill., May 13-17, 1957.

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Editorials • • •

Brand Name Drugs

More than 85 per cent of all prescriptions are prefabricated by the pharmaceutical manufacturer. They are not compounded by the retail druggist. Thus the integrity of the manufacturer becomes as important today as the honesty and cleanliness of the retail pharmacist was in 1900. Modern mass production, whatever its disadvantages, does guarantee standardization. One spoonful of a good brand's Elixir XYZ has the same composition and potency as another teaspoonful of the same brand's Elixir (if you use the same teaspoon). This is not true of a fly-by-night manufacturer of shoddy merchandise. But it *is* true of any of the reputable manufacturers who advertise in this and other physician-controlled journals.

Control is the secret of sound manufacture —control of purity, viscosity, solubility, potency, vehicle and particle size. To exercise control at every step of the manufacturing process is expensive. A manufacturer who ignores controls can sell his product cheaper. It may be announced as a "pharmaceutic equivalent"—but it isn't. It isn't an equivalent in potency, solubility, viscosity and so on, even though it looks like an equivalent in color of fluid or shape of tablet.

Fluids separate, tablets decompose, ointments can deteriorate and any medication can become contaminated. The honorable manufacturer determines the "shelf life" of a product and advises the retailer or marks an expiration date. This kind of determination is expensive. By stamping on an expiration date, the manufacturer stands to lose some sales. The third-grade maker avoids that danger. He doesn't determine shelf-life, or he stamps no accurate expiration date on the package. In that way he can sell his product at a bargain. Of course, the aspirin tablet may deteriorate and give forth the odor of acetic acid. Still, it's a bargain. Some bargain!

One of the oddities of the drug trade is that the manufacturer spends a fortune on research, and counts himself lucky to get one usable product out of fifty experiments. He pours down the drain the cost of the other

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49 projects. His purpose, to be sure, is not charitable. He expects it to pay off, hoping to make enough profit on the one successful experiment to pay the workers on the 49 wild goose chases. Still, if an unethical manufacturer can borrow the results of that research, he can undercut the original maker in price; the second company doesn't have to pick up the research tab. Hence, the by-passing of good brand-named products is a body blow to research. Why should a company spend millions in research to see their final products left on the shelf in favor of a cheaper substitute?

Chemically speaking, one antacid tablet may be the same as the other. Still, if you are chewing the tablet, you prefer the one with a smooth taste to one that tastes and sounds like a mixture of grit and chalk. And if you prefer the brand-named, more elegant tablet, your patient is entitled to it too.

A suppository that melts in the container before use—or fails to melt in the body cavity during use—is worthless no matter how cheaply it can be bought. Melting point control requires expensive equipment, and adds to the retail price. A first-class manufacturer, however, will not put out a suppository without a controlled melting point. A third rate manufacturer may do so. And he can sell it cheaper.

So the experienced physician is not defensive about prescribing brand-named products —or giving the retail pharmacist a choice of reliable brand names. He knows that the patient can buy an ersatz product a little cheaper. But precious things don't sell at cut-rate prices.

"Ancillary" is a Fighting Word

Officially you may call the organization of doctors' wives an "auxiliary." But as an individual, no wife will let you dub her "auxiliary" to anything. She's not a subordinate or peripheral part of your life. (Anybody want to argue with us about that?)

Another fighting word is "ancillary." It is from the Latin for "handmaiden." The essence of being a handmaiden is being subordinate, subservient or servile. From the viewpoint of the lone physician taking full responsibility for a sick patient, from his viewpoint, the laboratory and the x-ray department are, perhaps, "helping" him; and in that sense "auxiliary." But they are not "servile."

Except for mild illnesses in the office, most patient-care today is a team function, with the practitioner serving as a captain. The nine men on the ball team are all needed. Their functions are different, but you would scarcely call the short-stop servile to the pitcher, the left fielder subservient to the third baseman, or the pitcher ancillary to the field captain. Whether a "non-physician" can be an equal member of the team is an arguable point—let's save that for another day. But the physicians on the team are all brethren and are not to be echelonned along a pyramidal hierarchy. The pathologist, radiologist, anesthesiologist, physiatrist, resident and consultant are doctors of medicine each making a unique and precious contribution to a common goal. The family doctor or the treating physician has the awesome responsibility for final decision. Those who help lighten his labors and help divide that duty are his colleagues, not his servants. Let us extirpate that unfortunate word "ancillary" and place it (with "broad spectrum," "grass roots" and "armamentarium") in the grave-yard of useless clichés.

The Trivial Finding

How do you handle the minor finding—the slightly deviated septum, the meaningless diverticulum, the symptomless extra rib? Some doctors are enchanted by such findings, and explain faithfully to the patient how the slight clouding of a sinus causes headache or the extra hair on the face suggests endocrinopathy. Particularly when the patient is a worrier, is the minor finding treasured by the M.D. The constant complainer wears everybody down. And now the doctor can say with relief: "At last we have found the cause of your trouble: a dropping of the stomach!" And, sure enough, there it is on the x-ray film.

Many doctors, it has been said, have built practices on the platform of these trivial findings. These things save face for the neurotic, for he dreads the implication that the symptom is "all in the head." No matter how carefully the practitioner explains that a psychoneurotic symptom is *not* imaginary, the patient still thinks that he is being called names when that label is attached. So he is pleased with the trivial finding. And so is the doctor, for it is hoped that the patient can now stop being querulous and a sharply focussed treatment program can be initiated.

So if this innocent pass-time is pleasing to both doctor and patient, why should it be questioned?

Why indeed?

Because it rivets a concept of illness into the patients' thinking. Because it is scientifically inaccurate. Because the relief which follows is only temporary. Because it leaves the patient's basic problem unsolved and unresolved. Because it can convert a minor anxiety into a ceaseless preoccupation with one's organs.

Trivial finding . . . casual diagnosis . . . life-time hypochondriac.

Not all doctors have the courage to say that the symptom is essentially due to anxiety or to emotional conflict. For the doctor as for the patient the pathetic little minor finding is a way out.

But there are better ways.

Psychosomatics by Inference

While most doctors now acknowledge emotional factors in organic disease, there is still a reluctance to write such things down on paper. It is easier to write "peptic ulcer" on an office or hospital record than to say that the symptoms are basically due to "frustration with resultant hyperacidity." While this is a more meaningful formulation than "peptic ulcer," it just isn't the kind of thing that gastroenterologists and surgeons put down on their consultation reports.

It is as if medicine, being dedicated to the care and cure of the body, has to maintain its intraprofessional communications along "organic" lines. Or as if the doctor were afraid of being laughed at if he placed a psychological explanation on a hospital consultation sheet. He knows that anger can raise the blood pressure and that repressed hostility can increase gastric acidity. Everybody else knows it too. But a curious conspiracy of silence seems to prevail. Elaborate chemical studies are made of the gastric acidity and solemnly entered on the hospital chart, while the more significant emotional factors are discussed orally but never written into the records.

It is a kind of make-believe communication. The chemical and pathologic changes constitute the surface language while the psychological explanations of illness are understood by inference. This double talk seems to be necessary because the psychosomatic concept has penetrated the thinking of doctors but not their language.

J. Lawrence Pool, M.D.*
Alpine
James W. Correll, M.D.*
Ridgewood

Psychiatric Symptoms Masking Brain Tumor

There is a pathetic, poignant ineffectiveness about doing psychotherapy in the hope of exorcising an expanding brain tumor. We have become so enchanted with emotional factors in the production of symptoms that we sometimes forget organic components. This serious paper by Dr. Pool and Dr. Correll suggests some ways of avoiding this tragic error in patients with brain tumor.

Brain tumors, whether benign or malignant, may lead to personality disturbances for which psychotherapy instead of surgical treatment is initially administered. While this problem is not new,[1,2] patients with brain tumor continue to come to surgery who have been treated too long as purely psychiatric problems.

Granting the initial difficulty of accurate diagnosis, our analysis of 25 such patients indicates that certain cardinal symptoms could often have led to an earlier suspicion of brain tumor. Tragically enough, nearly half these patients harbored benign or indolent tumors with long life expectancy.

A 44-year old woman, for example, was treated with psychotherapy and electric shock treatment for 13 years because of a depressed state (Case 1), although during this time she suffered repeated spontaneous convulsive seizures and slowly developed left hemiparesis together with blindness of the right eye. At operation, while a benign tumor (meningioma of the right sphenoid ridge) was removed, the unfortunate diagnostic delay was responsible for a permanent motor and visual deficit.

Soniat[3] reports that one-half of a series of 128 patients with brain tumor exhibited symptoms which, on admission, could have been considered "psychiatric." Others[4,5] have also emphasized the fact that many patients with a brain tumor have some sort of mental symptoms. The incidence of brain tumor in the population of certain mental institutions,[6,7,8,9,10] furthermore, may range from 3½ to 13½ per cent, which is several times that found in patients of a general hospital.[11] This higher incidence is significant since it has been pointed out[4,12] that "psychiatric" patients are no more likely to develop brain tumors than those of the general population.

Clinical Findings

Of the 25 cases here reported, 14 of the patients had received psychotherapy or other

*From the Department of Neurologic Surgery, College of Physicians and Surgeons, Columbia University and the Neurological Institute, Presbyterian Hospital, New York.

TABLE 1.

PSYCHOTHERAPY

Case No.	Sex	Age	Psychiatric Diagnosis	Psychotherapy (months)	Path. Diag.	Location	Course
1	M	15	BEHAV. PROB. (HOMIC.)	48 Inst.	Oligo.	Tem., R.	No. op., Died
2	M	43	OBS. COMP.	24 (PA)	Gliobl.	Fro.-Tem., R.	Op.+X-Ray
3	F	40	DEPRESSION	24	Lympho.	Meninges.	Op., Died
4	F	33	DEPRESSION (SUIC.)	18	Gliobl.	Tem., R.	No op., Died
5	F	24	DEPRESSION	12	Epider.	B. Fro.	Total removal, Improved
6	F	34	ANOREXIA NERVOSA	12	Gliobl.	Tem., R.	Op.+X-Ray, Improved
7	F	16	DEPRESSION (SUIC.)	6 Inst.	Gliobl.	Tem., R.	Op.+X-Ray, Improved
8	F	35	ANXIETY STATE	6	Oligo.	Fro., R.	Op., Died
9	M	55	PARANOID; DEP.	6 Inst.	Mening.	B. Fro.-Par.	Partial removal, Improved
10	F	45	SCHIZO. (PARAN.)	2 Inst.	Cranioph.	Sub-Fro.	Op., Died (moribund on adm.)
11	F	63	SCHIZO. (PARAN.)	1 Inst.	Gliobl.	Tem., R.	Op., Died

ELECTRIC SHOCK TREATMENT (EST)

Case No.	Sex	Age	Psychiatric Diagnosis	EST (No. of Shocks)	Path. Diag.	Location	Course
1	M	53	INVOL. MEL.	10+	Mening.	Fro., R.	Died of EST (No op.)
2	F	50	PARANOID; DEP.	10+	Mening.	Fro., R.	Total removal, Impr.
3	F	55	INVOL. MEL.	3	Mening.	B. Fro.	Total removal, Impr.
4	F	57	INVOL. MEL.	10+	Mening.	Sph., R.	Total removal, Impr.
5	F	44	DEPRESSION	10+ Inst.	Mening.	Sph., L.	Partial removal, Impr.
6	F	58	MANIC-DEP.	10+ Inst.	Mening.	Sph., L.	Partial removal, Impr.
7	M	63	PARANOID; DEP.	6	Schwannomo	Acoustic, L.	Partial removal
8	F	49	DEPRESSION	14	Gliobl.	B. Fro. Por.	Biopsy, Died
9	F	32	DEPRESSION	10	Oligo.	Fro., R.	Op.+X-Ray, Impr.
10	F	53	INVOL. MEL.	5	Met. Co.	Tem., L.	Op.+X-Ray, Died
11	M	43	HYSTERIA; DEP.	3	Gliobl.	Tem., L.	Op.(2X)+X-Ray, Impr.
12	F	60	DEPRESSION	2	Gliobl.	Tem.-Por., R.	Biopsy+X-Ray, Impr.
13	M	48	DEPRESSION	3 Inst.	Gliobl.	Thal., L.	Died (No op.)
14	M	55	DEPRESSION	5	Gliobl.	Fro., L.	Op., Imp.

Legend for Table 1.
Inst. = Institutionalized
PA = Psychoanalysis
Epi. = Convulsive disorder
Fro. = Frontal
Tem. = Temporal
Par. = Parietal
Thal. = Thalamus
Sph. = Sphenoid
R. = Right
L. = Left
B. = Bilateral
Op. = Operation
Imp. = Improved

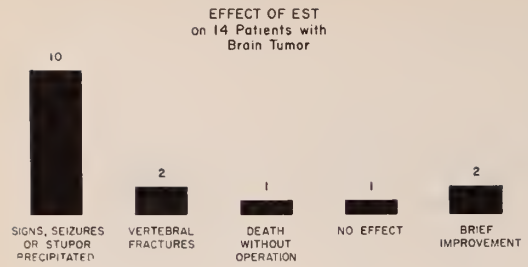
psychiatric treatment, for over one year. Eight had received such treatment for over two years; 4 for over three years and 2 had received such treatment for 13 years. See Table 1. The remaining eleven were so treated for periods of from one to twelve months.

Eleven had received psychotherapy alone. Fourteen were also given electric shock treatments. Eight of the 25 (an incidence of 32 per cent) had been confined to mental institutions.

Electric shock treatment often precipitated rapid progression of neurologic symptoms and signs (Fig. 1). Two patients, for example, became comatose while 8 others developed increasing hemiplegia or severe mental deterioration, persistent confusion, memory loss and/or incontinence of urine and feces.

Of the variety of psychiatric diagnoses in these patients, a depression of some sort was the most frequent. Depression was found in

FIGURE 1.



14 of the 25. Neurologic symptoms included olfactory and gustatory hallucinations, or visceral complaints such as epigastric distress, palpitations, a sense of body coldness, shortness of breath, shivering, or episodic pallor or flushing of the type associated with temporal lobe pathology.[16,17,23,24]

Definite evidence of an organic lesion of the brain was present prior to the onset of psychiatric treatment in 15 of the 25 patients. See Table 2. This was most commonly a convulsive disorder which occurred prior to the onset of psychiatric treatment in 10 patients, and prior to the termination of psychiatric treatment in 3 others. By the time of tumor verification, 11 patients had had seizures for longer than six months, 5 for longer than two years, and one for 22 years! In two patients who described minor seizures before psychiatric treatment was begun, appropriate *diagnostic evaluation was delayed for over one year,* until grand mal seizures occurred. In another patient a series of seizures occurred one hour after the first electric shock treatment, but *neurologic investigation was not carried out until three years later.* In two other patients seizures occurred six and four months before the conclusion of psychiatric treatment.

Psychomotor seizures occurred in 4 of the 10 patients who had convulsive disorders prior to psychiatric treatment. These were considered to be part of the psychiatric syndrome in two cases, whereas in the other two it was thought that they were less important than the psychiatric problem. One patient (Case 2), although diagnosed as a behavior problem with psychomotor seizures, also had other temporal lobe symptoms for which he was intensively studied. He died without surgery and was found, at autopsy, to have a massive hemorrhage from a small oligodendroglioma confined to the non-dominant temporal lobe. He should have been explored on clinical grounds.

Other symptoms which should have led to a suspicion of organic lesions in these patients included: headache, hemiparesis, diplopia, hearing loss with tinnitus, and progressive memory impairment associated with incontinence of urine (Table 2).

TABLE 2.

EVIDENCE FOR ORGANIC DISEASE

Prior to Psychiatric Treatment

Evidence	No. of Cases
Psychomotor seizures	4
Grand mal seizures	4
Petit mal seizures	2
Headache	1
Diplopia	1
Hemiparesis	1
Deafness and tinnitus	1
Memory loss and incontinence of urine	1
Total	15

During Psychiatric Treatment
(But treatment continued for 3 to 36 months)

Grand mal seizures	3
Hemiparesis	1
Total	4

Treatment Discontinued
(1 day to 2 weeks after appearance of symptoms)

Incontinence of urine and feces	1
Sensory loss and weakness	1
Total	2

FINDINGS

TEN patients harbored benign tumors and 3 relatively benign glial tumors (oligodendrogliomas). See Table 3. In 24 of the 25 cases the tumor was supratentorial and in 22 the temporal or frontal lobes were involved.

Six patients are living and well today, free of both neurologic and psychiatric symptoms one to eight years after surgery. Others could have been similarly saved had an earlier diagnosis of brain tumor been made.

TABLE 3.

OPERATIVE RESULTS

Total		Benign	Gliobl.	Oligo.	Met.
6	Living and well	5	0	1	0
6	Improved 6-plus months	2	4	0	0
9	Died after operation	2	4	1	2
4	Died without operation	1	2	1	0
25	Total	10	10	3	2

Of four other patients with solid extra-axial tumors, two had such large sphenoid ridge meningiomas by the time of operation that irreversible changes in the brain had taken place. Each had received psychiatric treatment for 13 years and one had been in an institution for many months with a diagnosis of schizophrenia. A third had advanced obstructive hydrocephalus due to an acoustic nerve tumor. Three months after successful subtotal tumor removal, he died of a pulmonary embolus. The fourth patient in this group, moribund on admission, had a craniopharyngioma.

COMMENT

SINCE successful surgical intervention resulted in striking neurologic as well as psychiatric improvement, it is particularly unfortunate that 4 patients died without operation. At least 3 other patients, moreover, had benign tumors which might have been completely or more effectively removed at an earlier date, thus preventing recurrence and death. It is therefore worthwhile to seek clues in the histories of these 25 patients that might have led to an earlier diagnosis, in view of the fact that 15 had historical evidence of an organic brain lesion prior to psychiatric treatment, while in 6 others, signs occurred after the onset of psychiatric treatment. See Table 2.

The frequency of a diagnosis of depression in our patients supports the findings of others.[13,14] Recently Weil [15] correlated temporal lobe-uncinate seizures with paroxysmal depressive reactions and electroencephalographic changes. Others [16,17] have noted the occurrence of temporal lobe lesions in patients suffering behavior problems. That the mental disturbances in such patients are related to their intracranial neoplasm is indicated by the fact that removal of their tumor alleviated the psychiatric symptoms.

Although most often the tumor location is supratentorial,[4,6] and involvement of the temporal and frontal lobes is frequent,[3,18] psychiatric symptoms may occur in patients with tumors in other parts of the brain. It has been suggested that the mental symptoms observed in some brain tumor patients are an intensification of an abnormal mental pattern already present. Certainly it is possible that any process which results in a progressive physical and mental deterioration may augment basic anxiety or some other existing aberrant emotional trend, although this is apparently not always true.

The frequency of temporal lobe tumors in our patients suggests that when clinical and electroencephalographic evidence points to a temporal lobe lesion, surgical exploration of the involved temporal lobe should be carried out, even though air studies and arteriography are negative. As Falconer [22] and others have shown, small removable temporal lobe tumors may be found at operation.

Clinical evidence such as convulsive disorder, particularly psychomotor seizures, or other temporal lobe symptoms must be considered to mitigate strongly against a psychiatric diagnosis. It would seem that when a psychiatric syndrome does not clearly fit into some definitely known entity, as Sands [25] has pointed out, or when seizures, temporal lobe symptoms, headaches or neurologic symptoms are elicited in the history, every effort should be directed towards excluding an organic brain lesion and, in particular, a brain tumor.

CASE REPORTS

THE following 5 of the 25 cases studied are presented to illustrate typical important features.

CASE ONE

Thirteen years before admission, when symptoms began, complete removal of this tumor might have been accomplished. The patient, a 44-year old female executive was first recorded as having difficulty in 1935, when repeated episodes of loss of consciousness sometimes associated with "spasms" led to increasing difficulty in verbal expression and weakness of the right extremities. The patient was hospitalized and described as semi-stuporous with right hemiparesis, right hemihypaesthesia, right internal strabismus, and aphonia. During a three-day period, she rapidly recovered, but was amnesic for the preceding two weeks. She was discharged with a diagnosis of *conversion hysteria of paralytic and amnesic type.* A few months later, she had a hysterectomy, and was then kept in a psychiatric hospital for treatment of "hysterical aphonia."

During 1944, 1945 and 1946, there were episodes of complete loss of initiative, anorexia, weight loss, and thoughts of suicide. These were assumed to be related to the suicide of an intimate friend. The patient also complained of visual difficulty for the first time.

In April 1947 she sought psychiatric help and was admitted to a psychiatric hospital as a case of "depression." Following 6 electric shock treatments, she suffered confusion and unsteadiness in gait. Then she seemed "uninhibited and euphoric."

In September 1947 episodes of vagueness and visual disturbances (being "unable to see out of the left eye") were considered hysterical. There was increasing tremor of the right hand with a "tremendous feeling of insecurity."

In November 1947 a second electroshock series led to transitory coma, after which she was described as being increasingly vague, incontinent and unable to walk without assistance. She was therefore placed in the disturbed section. A few months later, she was transferred to another psychiatric hospital where blindness of the left eye was recognized. Neurologic investigation revealed optic atrophy on the left and papilledema of the right eye (VOS O: VOD 20/200) with only a small part of the temporal field of vision remaining intact. In addition, aphasia and right hemiparesis were apparent. Plain x-rays of the skull showed evidence of increased intracranial pressure. Electroencephalography indicated focal changes over the left temporo-frontal area. A left sphenoid ridge meningioma was subtotally removed. After operation there was considerable mental and emotional improvement for over two years, followed by recurrence and death.

CASE TWO

Complete removal of an oligodendroglioma in the right temporal lobe might have been accomplished had this area been surgically explored on clinical grounds, although the pneumoencephalogram and arteriogram proved negative. This patient was never seen by a neurosurgeon. He was a 15-year old boy who experieneed his first convulsive episode at the age of 2. Afterwards a permanent residual left hemiparesis developed.

At the age of 4, repeated episodes of abdominal distress occurred which became more frequent between the ages of 6 and 8. Then the episodes of abdominal distress were associated with swallowing movements, peri-oral pallor, gross movements of the upper extremities, mention of a "red tinge" of his environment, and partial amnesia for some of these episodes. These attacks occurred at least once a month and frequently many times each day.

At the age of 11 a pneumoencephalogram was reported as normal.

A year later, he had become increasingly irritable, disobedient, and subject to frequent, violent, obscene outbursts. On two occasions he attacked his sister with a knife, threatening to kill. Each time he was hospitalized for psychiatric observation. Psychotherapy was continued thereafter.

At 14, the patient was recorded as being more aggressive, and at times facetious. Seizures were described as staring attacks accompanied by a sense of unreality—"things are recognizable, but look in some way different—sometimes objects seem more clearly outlined."

At age 15, the patient was admitted to the hospital on four occasions because of subarachnoid hemorrhages, during the last of which he died. Repeated bilateral carotid and vertebral arteriograms failed to show any definite abnormalities.

Postmortem examination revealed an oligodendroglioma in the right temporal lobe. A massive hemorrhage had occurred within this easily enucleable tumor.

CASE THREE

In this case initial symptoms, while definite, were neglected, so that a one year delay in treatment occurred.

One year before admission this 22-year old student nurse had an episode of suddenly feeling warm with flushing of the face and staring blankly while continuing to walk and listen to a friend talk, without being able to reply. These episodes recurred frequently over a two-week period and were often associated with jerking of the head from side to side. The patient was depressed and was repeatedly seen by a psychiatrist.

A few days before admission similar episodes were again experienced, but this time associated with momentary loss of consciousness, and finally with a generalized convulsion.

At operation a large, bifrontal, epidermoid tumor was grossly removed. For 7 years after operation the patient was free of mental symptoms or seizures and was fully employed. She is now being studied again for possible recurrence because of paranoid symptoms following a recent radical mastectomy for carcinoma of the breast.

CASE FOUR

The convulsive disorder in this patient was confused with a psychiatric syndrome, as were other symptoms such as abdominal discomfort, chills, shivering, olfactory hallucinations, and feelings of unreality which were not recognized as being typical of temporal lobe pathology.

A 33-year old housewife, over 18 months before death, began to experience frequent episodes of stomach pain, nausea and vomiting, chills and "loss of the sense of taste." Two weeks later she suddenly experienced an episode of a change in the state of consciousness accompanied by staring, involuntary walking, falling and "pounding the head against the floor." Periodic rigidity of the extremities, twitching of the left cheek, and a three-day period of amnesia followed. These episodes recurred frequently, associated with a feeling of coldness, shivering, buzzing in the head, the occasional "imagined smell of rubber," and a half hour period of amnesia and fatigue. At times, objects seemed distant, unreal or far away. Seventeen months before death a note by a hospital psychiatrist stated: "The patient is obviously upset, tense, restless and periodically has jumpy, bizarre movements of the body." The patient was also described as being severely depressed and suffering episodes of losing control and making hysterical self-damaging gestures.

Psychotherapy was begun and continued until the patient's death. On postmortem examination a glioblastoma was found confined to the right temporal lobe. This could have been radically removed and x-ray therapy been given with months or years of relief, as in other similar patients we have so treated.

CASE FIVE

Here is a case where impairment of memory associated with incontinence of urine should have suggested that thorough neurologic evaluation be carried out.

A 55-year old telephone operator, long considered emotionally unstable, suffered frequent nocturnal incontinence of urine and increasing irritability, loss of interest and initiative and impaired memory for 18 months prior to admission. Six months prior to admission a diagnosis of involution melancholia associated with enuresis was made. During an intravenous sodium amobarbital interview the patient was described as "grossly psychotic, ranting and raving, and at times quite incoherent and suicidal." Two months before admission 3 electric shock treatments were followed by marked mental deterioration. The psychiatrist then wrote that "the melancholia mellowed into a placid, childlike vacuous psychosis" associated with increasing disorientation and incontinence of feces and urine.

Plain x-ray of the skull on admission to our hospital showed downward, posterior displacement of the calcified pineal gland. Total removal of a large, bifrontal meningioma was carried out with striking postoperative improvement, the patient's sister stating that "the patient is a new person, now wants to live, and does not behave as she did before operation." There have been no abnormal findings on postoperative neurologic examination, and incontinence has ceased.

SUMMARY

1. A study is submitted of 25 cases of verified brain tumor in which there was serious delay of appropriate neurologic investigation because of prolonged initial psychiatric treatment. Fifteen of these patients showed definite evidence of organic disease of the central nervous system prior to psychiatric treatment. Four patients had such evidence 3 months to 3 years, or longer, before psychiatric treatment was concluded.

2. The most common manifestation of organic brain pathology in these cases was a history of a convulsive disorder, often psychomotor and frequently associated with other components of a temporal lobe syndrome. Other early symptoms or signs included headache, hemiparesis, diplopia, hearing loss and tinnitus, and progressive memory impairment associated with incontinence of urine.

3. Every effort should be made to recognize and investigate symptoms and signs of an organic lesion of the central nervous system in psychiatric patients as the benefit of early diagnosis and early surgical treatment is evident.[26] Aside from a careful history and neurologic examination, simple tests such as x-rays of the skull and an electro-encephalogram may lead to the correct diagnosis.

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A bibiliographic listing of 26 references appears in the authors' reprints.

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Cardiac Disability and Workmen's Compensation*

If the law holds that stress at work can provoke a heart attack, the employer will be unwilling to hire a cardiac. If the law denies that the stress of work can precipitate an attack, then the workman receives no compensation even when the coronary attack is due to vocational stress. A physiologic basis for a scientific resolution of this dilemma is offered by Dr. Roth.

In Workmen's Compensation procedures, cardiac cases have never bulked large. Thus in New Jersey, in 1955, there were only 48 cardiac claims out of more than 48,000 actions filed.[1] This accounted for less than about one-tenth of one per cent of the cases but it represented one per cent of the money awarded in Workmen's Compensation in New Jersey. The average cardiac case receives ten times the compensation awarded an average non-cardiac claim. This is due to the large number of fatalities included (20 per cent) and the magnitude of disability of the remaining cardiac cases.

Cardiac disabilities in compensation litigation readily separate into two categories. Rarely, cardiac disease is said to be due directly to bodily injury. More frequently, coronary artery disease and myocardial ischemia are alleged to have been initiated, or pre-existing disease aggravated, by a stress occurring at work.

CARDIAC TRAUMA

Few cases of direct cardiac trauma enter the compensation courts. Those that do are usually based on a proposed causal relation between trauma and a subsequent myocardial infarct. Occasionally, another type of cardiac damage is ascribed to trauma.

Trauma, acting directly on the heart, can cause damage to all types of cardiac tissue ranging from a transient arrhythmia,[2] and heart block[3] to the avulsion of a valve from its supports.[2] Serious injuries may occur without rib fracture—especially in young people with elastic rib cages. Most cardiac contusions are either fatal (with rupture and hemopericardium) or are transient, heal rapidly and may be overlooked in the assessment of damage if electrocardiograms are not taken frequently. There may be a latent period between the injury and cardiac rupture and the rupture may be preceded by electrocardiographic changes and aneurism formation. The electrocardio-

*Presented April 1, 1957 before the Section on Chest Diseases, Annual Meeting of The Medical Society of New Jersey.

1. Letter from Division of Workmen's Compensation, New Jersey Department of Labor and Industry, dated Jan. 28, 1957.

2. Barber, H.: Quarterly Journal of Medicine, 13:137 (1944).

3. Paulin, C. and Rubin, I. L.: American Heart Journal, 52:940 (Dec.) 1956.

graphic changes may simulate a myocardial infarct.[2]

Moritz has produced injuries strikingly similar to myocardial infarcts by light blows on the exposed epicardium of a dog's heart. These were accompanied by various arrythmias. Almost 20 per cent of the dogs developed ventricular fibrillation.[4]

It is occasionally asserted that coronary artery disease in the classic sense — that is, coronary thrombosis — is produced by direct trauma. This is extremely rare since the arteries are well protected by their surrounding fatty envelope. Most myocardial infarcts, developing after trauma probably are due either to the extreme stress and, possibly, shock or to a myocardial contusion.[5]

Helpern,[5] who has had extensive experience with the pathology of trauma, does not believe that buttocks injuries with "contre-coup," or abdominal compression, cause cardiac damage.

Occasionally, thoracic trauma may result in permanent, progressively disabling cardiac disease as in the following case:

A five-year old girl was seen in consultation several months after an automobile accident. She had always been in good health and had never had a heart murmur or any symptoms of rheumatic fever. She had been run over by a truck, and a wheel of the truck had passed obliquely over her chest fracturing the right clavicle and several of the left lower ribs. On examination, I heard a loud, harsh holosystolic murmur at the apex. There was roentgenologic and electrocardiographic evidence of left ventricular hypertrophy. Obviously, this child had had a traumatic rupture of the chorda tendinae of the mitral valve with resulting severe mitral insufficiency.

ARTERIOSCLEROSIS AND STRESS

THERE has been much medical debate on the relation of work to coronary artery disease. As our population ages, this will become increasingly important in forensic medicine. In truth, physical work, especially heavy labor may have a protective action in preventing the development of clinical coronary disease. Morris[6] has demonstrated much higher incidence of coronary disease in the sedentary workers in Britain's postal and transport services than in the more active bus conductors and postmen. He found that arteriosclerotic heart disease is more severe in the sedentary workers with a higher fatality rate and occurs at a younger age.[6] Some support has been given this view by Eckstein's experimental work.[7] He demonstrated that after narrowing — but not occlusion—of the left circumflex coronary artery in dogs, treadmill exercises resulted in an increase in collateral circulation as measured by retrograde coronary flow.[7]

This work, of primarily epidemiologic importance, has little bearing on the question of stress and subsequent coronary disease. For many years, workers with coronary disease, claiming compensation, have been told that decision is based on the existence of an "unusual stress." Myocardial infarcts were felt to be compensable only if the cardiac damage was immediately preceded by stress unusual for that man's normal work duties. This was based on the premise that coronary disease was a relatively static condition and that it was slowly but inexorably progressive. On this thesis, a man's work, with a constant load upon the heart, had little bearing on his disease. It was only an "extreme" stress, something for which the body was ill-prepared, that might cause cardiac damage. To take an example of this viewpoint carried to its conclusion, Willius[8] has stated that the "precipitation of a sudden closure of a coronary artery, already conditioned by a gradually progressive and definitely pre-existing pathologic process cannot justly be related to certain acts which may occasion temporary increased work for the heart."

The argument was also advanced that since most coronary occlusions occurred at rest or during mild activity, effort played no role in precipitating the catastrophe.[9]

This, however, is an oversimplification. Cor-

4. Moritz, A. R. and Atkins, J. P.: Archives of Pathology, 25:445 (April) 1938.

5. Helpern, M.: American Journal of Pathology, 25:783 (1949).

6. Morris, J. N. *et al.*: Lancet, 265:1053 and 265:1111 (Nov.) 1953.

7. Eckstein, R. W.: *Circulation*, 14:930 (Nov.) 1956.

8. Willius, F. A.: Industrial Medicine, 11:513 (Nov.) 1942.

9. Master, A. M., Dack, S. E. and Jaffe, H. L.: American Heart Journal, 18:434 (1939).

onary narrowing with diminution of coronary flow is *not* a static condition, nor is it necessarily a relentlessly progressive illness. In the chronically anoxic heart, the relation between oxygen supply and demand is constantly changing with effort, and with changes in the amount of collateral circulation. The coronary arteries were always regarded as end-arteries, anatomically, and exist this way in the normal. However, technics[10] for injecting coronary arteries with a fine lead-agar mass developed 25 years ago revealed numerous collateral vessels 40 to 80 micra in diameter in the chronically anoxic heart with occlusive coronary disease.[11] These vessels aided in revascularizing cardiac tissue, restoring the oxygen supply to near normal and mitigating the effects of anoxia due to the coronary arteriosclerosis. This anastomotic circulation occurs only in the anoxic heart and, according to Blumgart and Schlesinger,[10] developed only "when and where it is needed." The biologic stimulus is unknown, but may be due to the establishment of a pressure gradient. Artificial attempts to revascularize the heart, such as the Beck operation and Vineberg's implantation of the internal mammary artery, also do not succeed in the normal heart. They require the stimulus of anoxia.

Against this remedial process must be balanced the demand of the myocardium for oxygen. This demand, of course, varies with the work the tissue must do and, therefore, with the cardiac output.

10. Blumgart, H. L., Schlesinger, M. J. and Davis, D.: American Heart Journal, 19:87 (Jan.) 1940.

11. Blumgart, H. L., Schlesinger, M. J. and Zoll, P. M.: Journal of the American Medical Association, 116:91 (Jan. 11) 1941.

12. Blumgart, H. L., Zoll, P. M., Freedberg, A. S. and Gilligan, D. D.: *Circulation*, 1:11 (Jan.) 1950.

13. Friedberg, C. K. and Horn, H.: Journal of the American Medical Association, 112:1675 (April 29) 1939.

14. Gross, H. and Sternberg, W. H.: Archives of Internal Medicine, 64:249 (1939).

15. Snow, P. J. D., Jones, A. M. and Daber, K. S.: British Heart Journal, 18:435 (October) 1956.

16. Brofman, B. L., Leighninger, D. S. and Beck, C. S.: *Circulation*, 3:161 (Feb.) 1956.

THUS, the clinical picture and the life history of a patient with arteriosclerotic heart disease is determined by the balance between the progress of the occlusive disease, the myocardial demand and *the growth of collateral circulation.* The collaterals may develop with great rapidity. Blumgart[12] has shown that collaterals are present in the porcine heart nine days after a coronary artery is narrowed.

Thus, work of the heart becomes an important factor in determining the course of coronary disease. We all practice from this philosophy. Limiting the physical and emotional stress on a patient with angina is one example.

Other clinical examples of this fluctuation in adequacy of vascular supply and coronary reserve easily may be found. We all have seen patients with severe angina who spontaneously, slowly improved so that angina occurred only with great provocation. The anginal patient who becomes asymptomatic after a myocardial infarction is another example.

Obviously then, the adequacy of the coronary circulation varies from day to day in a patient with arteriosclerotic heart disease. The same work load may imply a different amount of stress to the patient's myocardium as the circulation varies. Viewed from this perspective, the "unusual stress" provision of the Compensation Law does not seem to fit.

The clinical emphasis on the anatomic alterations of the larger vessels derives from the days when pathologic investigations were morphologically oriented and did not concern themselves with flow and function. Infarction results from a disparity between cardiac work (demand) and coronary blood flow (supply) to the myofibrils. Infarction may occur without any thrombosis at all.[13,14,15] Infarction does not require total anoxia but may result from milder degrees of anoxia maintained for a long time. In fact, it has been suggested that the onset of angina or an increase in anginal severity calls for the assumption that a small infarct has occurred.[15]

The importance of anoxia in the precipitation of sudden death has been shown by Brof-

man, Leighninger, and Beck.[16] They report that in dogs the development of an anoxic area in the myocardium is accompanied by a 5 to 20 millivolt electrical potential between it and the surrounding well-oxygenated myocardium. This may easily go on to ventricular fibrillation and sudden death without acute anatomic findings—vascular or muscular. This can be demonstrated by partial ligation of a coronary artery. In reverse manner, it may be shown by asphyxiating the entire heart uniformly and perfusing one area with oxygen. An electrical potential is established with consequent instability and easily-produced ventricular fibrillation.

WORK AND CARDIAC DISEASE

THE application of these experiments to the problem of work and arteriosclerotic heart disease seems clear. If a workman with asymptomatic coronary artery disease and diminished "coronary reserve" of one portion of his myocardium exerts himself, he increases the work and oxygen demand of the heart. The decreased blood supply of this part of his myocardium, its vessels unable to dilate, cannot keep up with the demand. It becomes anoxic. Ventricular fibrillation and death may ensue. Thus, at times, stress — even that of an ordinary day's exertion — can be indicted as the provocative cause of sudden death.

The courts have anticipated the medical profession in this respect and the amount of stress has become less and less a factor in their judgments. In California,[17] for example, any cardiac disease in a policeman or fireman is presumed to be compensable. A watchman who suffered a myocardial infarct sitting at his desk was awarded compensation.[17]

EMPLOYING THE CARDIAC

THE time may be near when any infarct or sudden death occurring at work will be compensable. This may be more equitable from the medical standpoint than the present situation in New Jersey. This implies an extension of our present insurance coverage and the spread of Workmen's Compensation insurance and medical costs over a much wider area. It also spells further opposition to the employment of the cardiac—a problem which deserves consideration.

A survey in Massachusetts[18] of one hundred large employers who had 176,024 employees disclosed that 25 excluded cardiacs, 49 just "hadn't hired any," and 14 didn't know whether they had hired cardiacs. Of 13,439 workers in the entire group, only 99 were cardiacs. The reason commonly given by employers for reluctance to hire cardiacs was a feared increase in workmen's compensation insurance costs.

This is a misconception. Rates are mainly determined on an industry-wide basis and not by the experience of the individual employer (although they may be slightly affected by his "merit rating"). In fact, the Association of Casualty and Surety Companies[19] has stated:

> "Let this be understood — there is no provision in Workmen's Compensation insurance policies or rates that penalizes an employer for hiring handicapped workers . . . There appears to be much misinformation on this point. Many employers have been known to say they could not or would not hire disabled applicants because they had been advised that their insurance costs would be increased as a result. Nothing could be further from the truth."[19]

Yet, as time goes on, the employers' reluctance to embark on hazardous and possibly expensive experiments continues. Many of them realize the moral obligation of returning an old employee to work after he has had a myocardial infarct. But there is much confusion as to what he can do and what the employer's legal responsibility is. For the young rheumatic or the older worker with hypertensive or arteriosclerotic heart disease, most doors to employment remain shut.

In our aging population, with a coming

17. Thompson, J. H.: Archives of Industrial Hygiene and Occupational Medicine, 3:292 (1951).

18. Olshansky, S. *et al.*: New England Journal of Medicine, 253:506 (Sept. 22) 1955.

19. Quoted by Lane, M.: *The Effect of the New York Workmen's Compensation Law Upon the Employment of the Handicapped*, Institute of Physical Medicine, New York University-Bellevue Medical Center, New York, 1956, P. 40.

shortage of skilled labor and a constant lowering of the maximal hiring age, this may be a serious problem in the future.

Of the many solutions proposed to facilitate hiring of these people, the "Second Injury Law" seems the most feasible. Under this provision, an employer is liable only for that portion of the disability due to the present illness. As it is presently administered, there are several disadvantages to this law. In New York, for instance, the employer must be aware of the pre-existing disability. The courts there have held that there is no cardiac disability if the person is able to work—thus defeating the very aim of the law. The amount of liability the employer's carriers have, even with Second Injury Law coverage, is still high—about four thousand dollars. And possibly most important, the cardiac, in contrast to the amputee or other orthopedic disabilities, is likely to have more disability.[20]

However, these obstacles are subject to legislative action so that the risk of the employer hiring cardiacs may be spread over an entire industry. The only alternative would seem to be the compulsory hiring of the disabled, practiced in Britain and Scandinavia—not a very happy solution.

It is indeed ironic that the vast Workmen's Compensation system, designed to aid an injured workman, helps to bar him from resuming his place in a productive society.

20. Lane, M.: *op cit.*, p. 48.

SUMMARY

THE relation of cardiac disease to compensation has been reviewed. The role of trauma in causing cardiac disease is limited. Most of the controversy stems from the relation of coronary disease and work. Recent pathologic studies indicate that the fate of a patient with arteriosclerotic heart disease may well depend on the demands made on the myocardium at critical times. According to this view, some inequities are present in the "unusual stress law."

The present compensation structure has, paradoxically, led to difficulty in finding employment for the worker convalescing from a myocardial infarct.

707 Broadway

OASI Trust Fund Seems Stalled

In the first five months of the 85th Congress, the lawmakers introduced more than a hundred bills designed to broaden the Social Security Program in one way or another. Such open-handed proposals win acclaim, and more tangible rewards at the polls, for their sponsors. Years ahead of schedule, the growth of the Old Age & Survivors Insurance Trust Fund has come to an end. At the moment it is paying out more than it is taking in. This unexpected deficit should serve as a red flag to the Treasury, the taxpayer, and all who are looking forward to receiving retirement checks of their own. However generous its motives, even a federal pension fund cannot go on incurring obligations which exceed its resources.

OASI is a system under which the active workers and their employers are contributing the taxes necessary to pay benefits to their fellow citizens on the benefit rolls. The active workers now covered under the system must look for their own old-age benefits, not in any large measure to the trust fund, which is only a moderate buffer fund to cover temporary excess of benefit payments over tax receipts, but mainly to the willingness of the next generation of active workers to pay the increased taxes out of which the retirement benefits will come.

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Rehabilitation by Corrective Surgical Planing: (Dermabrasion)*

The young woman was miserable because of acne scars on the face. She met the dermatologist. Her face was planed. Her skin was restored. She was helped to live happily ever after. Fairy tale? No. According to the enthusiastic authors of this paper, it is all possible and it is all true.

"What can I do about these scars, Doctor?" was the frequent question asked by the victims of acne or other facial disfigurements. Attempts to flatten the sharp edges of the scars to make them cast less of a shadow were time consuming and not very satisfactory. Carbon dioxide slush or acid peeling gave only temporary improvement. Until Kurtin [1] perfected his technic of skin planing, the honest answer was a regretful, "Nothing." At best, these facial defects produced a constant mental anguish in most sufferers, a mild psychic disturbance in some, and even a severe psychosis in the susceptible few. We talk about facial defects chiefly, since it is in this location that they are most frequently bothersome; and here surgical planing produces the best results. The technic is well described in the literature.[1,2,3,4,5]

Here are the indications for planing:

1. Pitted scars resulting from:
   a. Acne infections
   b. Chicken pox
   c. Various other skin infections
2. Pigmentations:
   a. Freckles
   b. Chloasma
   c. Tattoos
3. Superficial Growths:
   a. Keratoses
   b. Intra-epidermic nevi
   c. Flat warts
   d. Superficial "port-wine" stains
   e. Sebaceous adenomas
4. Scars:
   a. Traumatic deformities where the edges are not quite at the same level and therefore cast a deforming shadow
   b. Hypertrophic deformities producing similar shadows
5. Wrinkles
6. Enlarged pores
7. Telangiectasia and Spider nevi

*Read at the Annual Meeting, Dermatologic Section of The Medical Society of New Jersey, April 30, 1957.

1. Kurtin, A.: Archives of Dermatology and Syphilology, 68:389 (1953)

2. Rein, C. and Blau, S.: Archives of Dermatology and Syphilology, 70:754 (1954)

3. Burks, Jonathan: Journal of the Southern Medical Association, 48:452 (1955)

4. Robinson, M.: Medical Annals of the District of Columbia, 24:17 (1955)

5. Strauss, J. and Kligmann, A.: Archives of Dermatology and Syphilology, 74:397 (1956)

These include most of the facial deformities present or developed. The ability to improve greatly or to remedy these is one of the greatest advances in dermatology of this generation.

To this point, it has been the dermatologist talking. But even the most objective approach by the physician fails to present the facts brought out by the patient.

In my time spent in the office of the late Dr. Kurtin, I (S.H.) was at first worried about the apprehension of the patient before the first planing. This was rapidly replaced by amazement at their enthusiasm at the second or third planing. This has been almost a constant feature in my patients also. Only the experience itself can convince the patient that the removal of the skin of the entire face can be performed *with no pain whatsoever* and can be followed by only 24 to 48 hours of burning and swelling while the crust forms. The prechilling of the skin with a cold pack for thirty minutes before the planing reduces the shock to the skin caused by the application of the refrigerant. After this, the procedure is painless unless an area of unfrozen skin is planed by accident. The next day, swelling begins and can be a nuisance but is not painful. This is chiefly about the eyes and chin where dependent edema is most noticeable. During this period, there is also considerable oozing which usually requires mopping up since the perforated plastic-faced covering does not absorb it all. This is also only of "nuisance" discomfort. It is our practice to have the patient remove the bandages at home after forty-eight hours. The plastic-faced bandages are readily removed without sticking. When the dressing is removed, a bloody crust is present. The sensation is one of a severe sunburn and the patient is now more uncomfortable than at any other time in the convalescent period. When the crust is forming, many patients find it difficult to open their mouths. Some are relieved by applying petroleum jelly. Others resort to the use of a straw for twenty-four or thirty-six hours, after which the crust softens up. At this time, only faith in the doctor keeps up the patient's morale. The face looks as though it will never be the same. And, indeed, this is the truth. It *will* never be the same. Within fourteen days, the crust has separated, and although the skin is red, at least 50 per cent of the scars are gone.

During these two weeks, new skin grows from the remaining deep pilo-sebaceous structures. The speed of this growth varies with the depth of the planing since the deeper the planing, the fewer pilo-sebaceous structures left. A superficially planed area will be free of crust in eight days, whereas the area around a deeply planed "ice-pick" scar may still have a small crust after two weeks. Healing occurs first at the outer shaded edges of the planing and in scattered patches where no defects existed and planing could be done "once over lightly." Our advice to the patient during the late healing period is to use petroleum jelly at night on loosening areas, compress the face with a luke-warm boric acid solution in the morning, and then to cut off the loosened crusts with a sterilized cuticle scissors. This routine removes the annoying loose crusts each day. No crusts are pulled off since this takes the newly grown epithelium with it. The patient returns to work on the 14th postoperative day taking the advised precautions to avoid all sun and medicines on the newly healed skin for four weeks, and a sunburn for an additional four weeks.

Once having experienced this relatively painless procedure, most patients eagerly await any needed subsequent planings. Nonworkers want to finish their necessary "repeats" as soon as possible in order rapidly to complete their rehabilitation. Workers frequently have to postpone their "repeats" until their next yearly vacation which they gladly sacrifice for fourteen days at home recuperating. There are two chief reasons for this: The first is the relative ease of the procedure. The second is the patient's urgent desire to be rid of any facial disfigurement.

The medical literature abounds with articles on how facial planing is performed, its indications, contra-indications, complications, and

"before" and "after" pictures. Some even give short case histories. It is inconceivable to think that any man or woman included in one of these articles had not been bothered by the deformity pictured as "before" or not relieved of some inhibitions when looking like the "after" photo. Our records include a number of patients whose social attitudes were twisted because of their facial disfigurements. These were restored to normal activities by successful planing. One young man never joined the others because of his self-consciousness over hypertrophic scars of his neck. A young woman refused to make dates during the day because in daylight the heavy make-up she wore looked like a mask. Two months after her second planing, at the age of 30, she was happily married. Another young woman was a recluse because of her scarred face. Following facial planing, she became engaged, was married, and is now a happy housewife. There is the grade school girl who was so upset by her extensive freckling that the consultant psychiatrists felt that their removal would be beneficial. The freckles were successfully removed and one obstacle in her social progress was corrected. These are the more striking case histories in a relatively small series.

The popular magazine articles are filled with case histories such as the one of the engineer who was denied an executive position because of his acne pitted face,[6] of the teenager, who couldn't become a nurse for the same reason,[6] of the young insurance worker who refused a promotion because acne scars made him uncomfortable with strangers,[7] and the self-conscious youngster teased by her friends because of a pigmented mole on her forehead.[7] These histories end like fairy tales. They met the physician, had the necessary planing, and lived happily forever after. In view of our own case histories, these are not figments of their authors' imagination.

IN GENERAL, these patients have suffered with ther skin disfigurements only through necessity since no remedy was then available to them. They were forced to make the best of the situation. Some used extremely heavy make-up, some used none. In all but a few cases, psychic trauma of varying degrees resulted. This can now be prevented by avoiding the usual long delay in obtaining treatment and the prompt elimination of these disfigurements. This new procedure, by improving the appearance of the skin, serves to restore the patient to a more normal social life.

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6. Honor, Emile: "Cosmetic Surgery." Cosmopolitan Magazine, August 1956

7. Wolfson, M.: "The Miracle of Planing." Coronet Magazine, January, 1956

50 South Munn Avenue

7 Watchung Avenue

Job Opportunities in Baltimore

The Social Security Administration has vacancies for full-time and part-time medical consultants in its Division of Disability Operations, responsible for determinations of disability under the Social Security Act. These positions are available in the headquarters offices in Baltimore.

Incumbents will receive all federal Civil Service benefits such as retirement, life insurance, and vacation and sick leave privileges. The salary range is $10,065 to $11,395 a year. The salary in part-time positions is on a per diem basis.

These positions afford excellent opportunities for participation in clinical work and study in the city's nationally recognized hospitals.

Physicians interested in positions may write Chief Medical Consultant, Division of Disability Operations, 200 West Baltimore Street, Baltimore 1, Maryland, for further information.

Reuben Yontef, M.D.

Bayonne

Perphenazine* as a Tranquilizer in Dermatoses

The skin is a vast sounding board for the emotions. Dr. Yontef here reports that one of the newest calmatives, perphenazine, accomplished superior results in the treatment of 33 out of 89 patients suffering from a variety of dermatoses.

Dermatologists have long recognized the relationship between emotional tension[1] and skin diseases.[2,3] Before the tranquilizers were introduced, bromides, barbiturates, and chloral hydrate were often prescribed to reduce the emotional component. These drugs, however, are habituating and usually produce a degree of sedation undesirable among ambulatory patients. The tranquilizers offer the possibility of reducing tension and anxiety without causing drowsiness or addiction.

This report summarizes results among patients with dermatologic diseases who were treated with perphenazine,* a tranquilizer in the phenothiazine class.

DIAGNOSES

acne	21
acne with excoriations	6
alopecia areata	4
alopecia	4
dermatitis, allergic	5
dermatitis, atopic	4
dermatitis, seborrheic	4
neurodermatitis	4
erythema multiforme	1
eczema nummulare	4
herpes zoster	1
lichen planus	2
pruritus ani	6
pruritus vulvae	3
psoriasis	16
psoriasis, seborrheic	1
urticaria	2
vascular ulcer	1
Total	89

METHOD

Perphenazine was administered to 89 patients with dermatoses listed in the table. At first we used 8 milligrams 3 times daily, but it soon became apparent from the frequency of side effects that this dose was too high. Thereafter, most patients received 4 milligrams 3 times daily as a starting dose for a few days. The dose was then reduced to 4 milligrams twice daily and eventually stabilized at 2 to 4 milligrams once a day. I used no topical therapy in this group of patients since I wanted to determine if perphenazine*

*The perphenazine (Trilafor®) used in this study was provided by G. Kenneth Hawkins, M.D. of the Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey.

1. LeVan, P., and Wright, E. T.: California Med., 85:87 (August) 1956.

2. Noojin, R. O.: Southern M. J., 49:149 (February) 1956.

3. Reiss, F.: Psoriasis and Stress. Dermatologica, 113:71 (August) 1956.

alone could relieve tension and anxiety, and reduce physical symptoms.

RESULTS

Perphenazine relieved tension and anxiety in all 89 patients. In 33 of these, emotional improvement was accompanied by a significant diminution of physical symptoms. Results in this group were considered highly satisfactory.

Improvement of physical symptoms was absent, slight, or temporary in the other 56. However, the reduction in emotional tension which followed therapy with perphenazine enabled these patients to endure exacerbations with a certain amount of tranquility.

On 12 milligrams daily, 5 of our 89 patients (6 percent) experienced one or several of these side effects: coughing, vertigo, "nervousness," muscular tremors, "tightness" in chest, insomnia, fatigue, drowsiness. The latter two were most common.

COMMENT

Our results approximate those obtained by other investigators who used various tranquilizers in dermatologic indications. Ferguson [4] had been using azacyclonol (Frenquel®) in the treatment of schizophrenia in hospitalized patients; 19 of these patients also had psoriasis. He discovered that improvement of the psoriasis occurred in 16. Fisher,[5] who used chlorpromazine (Thorazine®) in schizophrenics, also found that psoriasis in a few patients cleared coincidentally with administration of the tranquilizer and recurred when medication was discontinued. Schmitz,[6] using chlorpromazine, reported favorable results, chiefly a marked reduction in pruritus, in 99 of 100 patients with skin disease. He suggested that tranquilizers be used as ancillary therapy even in nonpruritic skin disorders.

Rein and Fleischmajer [7] used ethchlorvynol (Placidyl®) in 108 dermatologic patients in whom pruritus or an obvious tension component was present. Sixty per cent of this group reported less itching and an increased ability to relax.

Robinson and colleagues [8] reported on 159 patients with psychogenic dermatoses, of whom 132 experienced significant relief from tension after administration of hydroxine (Atarax®). These investigators substituted placebos in some patients who had improved on the tranquilizer; relapses invariably occurred.

Meprobamate (Miltown®, Equanil®) was used in dermatology by Cahn [9] and Lewis.[10] Results were generally favorable although Cahn [9] reported 3 instances of allergic skin reactions to meprobamate. This is a relatively frequent side effect of therapy with meprobamate and therefore this drug may be unsuitable in dermatologic patients.

Leslie [11] and Wolfram [12] reported on experiments with reserpine. This antihypertensive has marked tranquilizing properties. Wolfram[12] found reserpine especially beneficial in pruritus. In combination with local therapy, its good effect was about 50 per cent greater than when the specific therapy was used alone. Neurodermatitis and eczema responded especially well.

PERPHENAZINE*

Perphenazine,* introduced late in 1956, is among the newest of the tranquilizers. It acts somewhat like chlorpromazine. Perphenazine* is 6 or 7 times more potent than the older analogue and free from some of its side effects (hypotension, jaundice, agranulocytosis). Perphenazine* has been used chiefly among psychiatric patients but it is also valu-

4. Ferguson, J. T.: Antibiotic Med. & Clin. Therap., 3:146 (July) 1956.

5. Fisher, R. A., and D'Silva, J. L.: Illinois M. J., 110:135 (September) 1956.

6. Schmitz, R.: Excerpta Medica, 10:222 (Section XIII) 1956.

7. Rein, C. R., and Fleischmajer, R.: A.M.A. Arch. Dermat., 75:438 (March) 1957.

8. Robinson, H. M., Robinson, R. C. V., and Strahan, J. F.: J.A.M.A., 161:604 (June 16) 1956.

9. Cahn, M. M.: J. Albert Einstein M. Center, 4:161 (September) 1956.

10. Lewis, G. M., and Torre, D.: Am. J. M. Sc., 233:573 (May) 1957.

11. Leslie, G.: Monographs on Therapy, 1:29 (October) 1956.

12. Wolfram, St.: Rev. Allergy & Applied Immunol., 11:28 (January) 1957.

able in hyperemesis and where somatic illnesses are complicated by tension and anxiety. In addition to its relative freedom from side effects, a major advantage of perphenazine* is its flexibility. In properly adjusted doses it can be used in a broad range of emotional, psychosomatic, and psychiatric indications.

Parish[13] used perphenazine* in 129 patients with allergy, asthma, or dermatoses and reported significant relief of tension and anxiety, usually followed by improvement in physical symptoms, in all but 3. Reiss[14] selected 52 patients with dermatologic diseases obviously precipitated by emotional factors and treated them with perphenazine* alone. Results were good in 31 patients. Shanon[15] found perphenazine especially useful in relieving pruritus; this symptom occurred in 144 of 308 patients whom he treated with perphenazine* and was completely or partially relieved in 90. When a placebo was substituted in patients who had responded, pruritus recurred in all.

Neither perphenazine nor any other tranquilizer is specific therapy for dermatoses. However, tranquilizers are valuable adjuncts to other types of treatment. They reduce the emotional component which is significant in many of these patients. The effectiveness of the calmative drugs is proportional to the etiologic importance of the emotional component.

The dose of perphenazine* must be adjusted for each patient. Optimal dosage among ambulatory dermatologic patients can be generalized as 2 to 4 milligrams 3 times daily to start, with gradual reduction to maintenance levels as improvement occurs.

13. Parish, F. A.: Medical Times, in press.
14. Reiss, F.: Personal communication, 1957.
15. Shanon, J.: Personal communication, 1957.

SUMMARY

PERPHENAZINE* was administered to 89 patients with dermatoses presumed to be at least partly psychogenic. Usual dosage was 4 milligrams 3 times daily, gradually reduced to 2 or 4 milligrams once daily.

Results were very good in 33 patients who, following a short period of therapy with the drug, demonstrated relief of physical and psychic symptoms and maintained improvement on reduced doses. In 56 patients the emotional difficulties improved but relief of physical symptoms was absent, slight or transient.

Five patients experienced side effects, most commonly fatigue and drowsiness.

Perphenazine* appears to be useful in dermatoses to control the emotional component which is usually present in these conditions.

851 Avenue C

Obesity in the Aged

Obesity frequently leads to serious diseases such as diabetes and heart disease. So said Dr. C. N. Long, professor of Physiology at Yale University. Dr. Long said that there is evidence to show that diabetes and heart disease are more prevalent in overweight persons. Most overweight cases are due solely to overeating, according to Dr. Long. He said that dietary measures usually will correct overweight, suggesting that the habit of overeating originated with early man who found it necessary to store fat and calories for times when food might not be plentiful or available. Dr. Long said that since this storing process is no longer necessary, particularly in the more prosperous countries, it is now a misused physiological process. The talk was part of the AAGP's symposium on geriatrics in New York on November 8, 1957.

Anthony P. Randazzo, M.D.
Passaic

Two Complications of Uterus Didelphys

Some strange complications of pregnancy may be due to an unsuspected uterus didelphys. Dr. Randazzo here points out how such a malformation may be diagnosed and what can be done about it.

Uterus didelphys is a rare malformation which for the most part goes unnoticed since it produces no symptoms. However, it may lead to a grave gynecologic disturbance, difficult to diagnose and treat. The phrase *uterus didelphys* identifies two well defined and entirely separate uteri, having no connection with each other and no dividing wall. One tube and one ovary accompanies each organ. There may be a single or double cervix and a single or septate vagina.

The tubes, uterus and vagina are formed entirely by the Müllerian ducts. The upper part of these ducts is destined to become the fallopian tubes; the middle part becomes the uterus, and the lower third, the vagina. They are formed and run parallel to the Wolffian ducts. In their upper extremity, they are far apart, but in their downward course toward the uro-genital sinus the Müllerian ducts approach each other, coming close together in the lower third. After the eighth week of intrauterine life the Müllerian ducts of this portion begin to fuse. This fusion always starts at the lowest extremity and extends upward until the lower and middle third have become firmly united, completing the vaginal and uterine canal at about the fifth month; but the upper third always remains apart.

If the pattern of union at this early period of embryonic life is interrupted at any portion, each duct may develop separately and independently. This results in the formation of double organs (uterus and/or vagina). If fusion of the lower third of the ducts has already begun before the inhibitory influence has been brought into play, that portion will continue to grow as a single organ, while those parts, the union of which has been prevented, will develop separately and independently as double organs. In the cases to be reported, there was some such impediment to the fusion of the Müllerian ducts in the early part of the third month of fetal life, after a portion of the lower third had already become fused. The latter continued to develop into a normal vagina, while those sections of the ducts which remained separate formed two separate uteri.

Graetzer [1] attributed double uterus to fetal peritonitis, with the peritoneal bands acting as a mechanical barrier to the fusion. This theory fails to explain the uterus septus. Pfannenstiel [2] held that an exceptionally broad pelvis produced a greater separation of the Wolffian bodies and consequently the Müllerian ducts. In 106 cases of duplication of the uterus, in which the writers mentioned pelvic meas-

1. Graetzer, Rudolf: Verhandlung des Deutschen Pathologisches Gesellschaft (Jena), 14:412 (1912).
2. Pfannenstiel, Adolf: Zeitschrift fue Sexualwis-senschaft von Basle, 4:818 (1908).

urements, only six showed any abnormal width, the external measurement between the crests of the ileum in these six cases having varied from 29 to 33½ centimeters. Uterine duplication has been found in patients with generally contracted and laterally contracted pelves. This does not support the "broad pelvic" theory. Furthermore, a wide pelvis in the adult does not necessarily presuppose a wide pelvis *in utero*.

R. Meyer[3] described a *uterus bicornis* with abnormally thick, short, round ligaments with a broad insertion, and then suggested that this condition of the round ligaments was the cause of all the forms of double uterus, excepting the uterus bilocularis. The latter, he believed to be due to an increase in the physiologic rotation of the Müllerian ducts around the Wolffian ducts. He actually demonstrated several bilocular uteri in which there was an abnormal direction of the *arbor vitae* (plicae palmatae) in the cervix. Pick[4] showed that the plicae palmatae are not remnants of fusion, since he found them in the uterus unicornis. He also found two main trunks of the *arbor vitae* and abnormal directions of the branches in normal uteri. All of this suggests that while abnormal directions of the plicae may be due to increased rotation of the ducts, the latter is not the cause of the anomaly.

Frankl[4] suggests that the caudal ends of the Wolffian bodies shrink under normal conditions, the atrophied portions forming the *plicae inguinales*. A part of the *plicae inguinalis* on each side becomes the round ligament through the addition of muscle fibres which grow into it. If this shrinking of the Wolffian bodies is delayed, the *plicae inguinales* will be shorter than normal at the time when the round ligament is developing, and in consequence the round ligament will also be shorter. The mechanical action of the shortened ligaments will then prevent the coming together of the Müllerian ducts.

It is possible that Meyer's round ligament theory[3] may throw light on solving the problem met in the present case reports which follow.

3. Meyer, Rudolf: Schwiezerische Blatter for Gesundheilsplege, 27:1101 (1919).

4. Frankl, Fransisco: Semina Medica Espanola (Barcelona), 31:8 (1914).

CASE ONE

A 22-year old woman reported that, while on an automobile ride, she experienced generalized abdominal pain which she thought was caused by eating a salami sandwich. The pains persisted and she vomited. The following night, she summoned her physician. Enematae brought no results. Examination disclosed generalized abdominal distention. The entire abdomen was sensitive and acutely tender, especially the uterus. Two more enematae were ineffectual. The patient again vomited. She was hospitalized with a tentative diagnosis of placenta abruptio (premature separation of a normal placenta) with a concealed hemorrhage or possible intestinal obstruction. X-rays revealed the following:

"Examination of the abdomen shows a pregnancy of approximately six months' duration in the left occiput position. Several greatly dilated loops of intestine are outlined by gas. In the erect position several fluid levels are present in the right upper quadrant, epigastrium and left lower quadrant. The findings suggest an intestinal obstruction. It is difficult to state whether the loops in the epigastric region represent small or large intestine."

On opening the abdomen, the entire uterus was found covered by a black, thick veil which seemed at first to be a gangrenous omentum. Actually, it was a veil of organized blood, leading to a clot, the size of a grapefruit, in the left pelvis. Free blood appeared in the peritoneal cavity. After removing the clot, blood came more freely from the left culde-sac. The pregnant uterus was seen to have one tube and an ovary which had a short, strong ligament which was attached close to the uterus about one inch below tube (abnormal) lower down. A second uterus was found in the transverse position, with the fundus toward the lateral brim of the pelvis, held by a strong, short, thick, round ligament beneath which hemorrhage was active. The second uterus was hypertrophied and the size of a small eggplant. Both uteri joined a common cervix at the internal os. This second uterus was removed to get at the bleeding point which came from a ruptured ovarian artery just as it entered the suspensory ligament of the ovary. One ovary and one tube was attached to the second uterus. The bowel was markedly distended proximal to its cohesion to the broad ligament and collapsed below it. Fetal movements were palpable in the pregnant uterus.

The two didelphous uteri here were in the longitudinal plane. The right uterus became pregnant and began to grow, causing the left uterus to be pulled up at the cervical end. Because of its short, thick, round ligament, it came to lie in the transverse position. It is

suggested that the pull continued and the broad ligament of the left uterus was put on the stretch, so much so that some undue strain, such as the automobile ride, ruptured the ovarian artery as it entered the infundibular ligament, resulting in a broad ligament hematoma. This hematoma, plus the pregnant uterus, caused sufficient pressure to occlude the sigmoid and cause an intestinal obstruction.

Incidentally, the literature shows that almost every pregnancy in a didelphic uterus is on the right side.

Pathologic report: Specimen consists of segment from uterus, measuring 8 by 3 by 4 centimeters. On sectioning it apparently contained an endometrial cavity, which showed marked thickening, grayish, whitish polymoid, endometrium. The myometrium is tan. Separately received is an ovary measuring 3.5 by 2 by 1 centimeters. It contains many pinhead to small pea-sized, thin-walled cysts; in addition, a small plum-sized thin-walled cyst, filled with clear fluid.

Microscopic section of the uterus shows transformation of the uteri mucosa into decidua. The decidua shows areas of inflammation and necrosis. Ovarian tissue shows follicular cysts.

Diagnosis: Segment of uterus showing the changes seen in late pregnancy. Ovary with follicular cysts; small par-ovarian-cyst.

Progress: Because of the great loss of blood, transfusions were given; one the following day by an Rh positive donor. After the transfusion, the patient became violent, her temperature rose to 106. When the patient became rational, a continuous intravenous was started containing penicillin. On the third day patient was distended and a Miller Abbott tube was inserted. From there on the course was uneventful and the patient was discharged 17 days after the operation.

The patient was observed at frequent intervals, and no fetal heart was heard at any time, although patient insisted she felt life. One month beyond the expected delivery date, she was x-rayed again. The findings follow: "Examination of the abdomen shows a fetus the size of a six month pregnancy in the vertex presentation with the head floating very high. The fetal skull shows marked overriding at the sutures." Overriding at the sutures together with the small size of the fetus in relation to the duration of the pregnancy are indicative of fetal death, which must have resulted at time of tranfusion. A week after the x-ray she was operated on, and here are the findings: Uterus was globular with one tube and ovary. The musculature was thin, almost transparent and collagenous in appearance. It was not as large as the corresponding period of pregnancy.

The uterus was opened and a macerated fetus was delivered. Because of the non-controllability of the musculature and because closure was impractical, a hysterectomy was performed.

CASE TWO

A 13-year old girl was admitted to the hospital with an "acute abdomen." She had a high leukocyte count and the diagnosis was acute appendicitis. At laporotomy, we found a tremendous right fallopian tube distended with blood. This tube had to be pushed aside. The appendix was found adherent to the undersurface of the tube and broad ligament. Because of the inflammatory condition of the appendix and the changes in the tube, the tube was amputated before the appendectomy was done. On cutting the tube from the uterus it was noted that a considerable amount of black, thick, hemorrhagic fluid oozed from the opening at the attachment of the tube in the uterus. The ovary was filled with blood and had to be amputated.

When the tube and the ovary were removed it was noted that there was a mass on which the uterus was sitting. This mass was continuous with the uterus at the lower end involving the entire pelvis. The mass was globular, firm and non-fluctuant. It appeared to be one structure with an anular constriction where the uterus and the mass continued into the entire pelvis. It was felt at this time that it was a possible neurogenic retro-peritoneal tumor or possibly a teratoma or chordoma. The appendix was removed and the operation terminated with a feeling that further surgery would have to be done at a later date.

In looking over the tube a suspicion of a possible ectopic pregnancy presented itself although this had not ruptured the tube. Pathologic reports, however bore out that fact that we were dealing with a hemato-salpinx and a follicular cyst of the ovary with hemorrhage over and above the appendix. The patient went home. Her next menstrual period was accompanied by considerable pain. A gynecologist was consulted who felt that there was a tumor in the pelvis and that it might be of malignant origin. Accordingly, an exploratory laporotomy was done. Reflecting the peritoneum adjacent to the mass, the mass was incised for biopsy. On cutting this mass, entry was made into what appeared to be a large cyst-like structure containing thick, old tarry material. This material was removed in large quantities and the mass reduced in size. It was then delineated as being definitely continuous with the body of the uterus. After dissecting this mass free, the ureter became apparent, as well as several of the hypogastric vesse's in the retro-peritoneal space of the broad

ligament. The free mass now tapered off into what was apparently a cervical tip and this tip became attached as a fibrous bud to the side of another cervix. By this time it was possible to bring up another uterus which was buried laterally and inferiorly by the mass. This uterus was perfectly normal in character except that it had an ovary and tube on its lateral (left) side. There was no other structure attachment to the right lateral side.

The uterus because of its position and incarceration had a curved banana shape. When it was straightened out it was definitely determined to be a normal body of the uterus and cervix. The other cervix had no external passage to the vagina, consequently on menstruation it had become a large hematometria. After amputating this cervical rudiment and peritonealizing the entire area the normal uterus was brought into midline and the abdomen closed in layers.

The patient has enjoyed regular, painless menstrual periods since her operation.

SUMMARY

Two complications of didelphic uteri have been presented. These abnormalities in the development of the uterus are of no clinical significance unless the patient becomes pregnant or unless there is complete atresia of one of the cervical canals. Some patients with double or septate uteri will go to term and deliver vaginally without much difficulty.

82 Prospect Street

Surgery for Parkinsonism

Some victims of Parkinson's disease are being returned to normal life by chemopallidectomy, said a panel of the fourth annual Graduate Symposium on Geriatric Medicine in New York on Nov. 7, 1957.

The symposium is co-sponsored by the American Geriatrics Society and the American Academy of General Practice under a grant from Schering Corporation, Bloomfield, N. J.

Chemopallidectomy, which has been practiced for five years, is designed to suppress the tremors and rigidity which are the major crippling effects of parkinsonism.

In operations performed during 1956, about 85 per cent of the patients showed marked improvement. A year earlier the figure was 70 per cent.

Ability to perform such simple everyday functions as dressing, eating, and walking was returned to the patients operated upon whereas a test group of patients not operated upon experienced progressive loss of the ability to function normally and to work.

Several before-and-after cases were shown in a film of actual patients. The most striking example was that of a thirteen-year-old girl who was completely helpless and had such severe involuntary movement that she could not sleep except under heavy sedation.

After chemopallidectomy this girl was shown leading a normal life and so improved that she could walk almost normally, take care of herself, go to school, play ball, and even dance.

With an over-all mortality rate of less than three per cent, it was reported that there had been no fatalities in the last 100 chemopallidectomies performed.

Moderator of the panel was Irving S. Cooper, M.D., Director, Department of Neurologic Survey, St. Barnabas Hospital, New York City.

Members of the panel were Norman William Davidson, M.D., Medical Consultant, Department of Neurosurgery, St. Barnabas Hospital, New York City; Gonzalo Bravo, M.D., Instructor of Neurosurgery, New York University; and Manuel Riklan, M.D., Chief of Psychologic and Vocational Services, St. Barnabas Hospital, New York City.

Ronald W. Lamont-Havers, M.D.

New York, N. Y.

Home Care of the Arthritic Patient*

Medical practice is becoming increasingly hospital-centered. As a result the home-bound patient tends to get thrown to the periphery of medical care. Yet here is a vast area for medical care, one in which the physician functions not as a day by day therapist but as the captain of a team. If the doctor of medicine refuses to lead home care projects like this, some other professional group certainly will.

The number of people who are confined to their homes or to some type of institution because of a form of arthritis or rheumatic disease is not known. However, figures obtained from an area where a well developed home treatment program is offered would indicate that in any one year, there are more than 54 such patients per 100,000 population to whom assistance should be given.[1] Thus in New Jersey there are probably at least 2,700 such patients. These figures do not represent all who are homebound because of arthritis. The results of a survey of the recipients of aid to the permanently and totally disabled would also indicate that the housebound arthritic presented a problem.[2] See the table. Over 42 per cent of those housebound were *not* confined to the bed or a chair and thus might be expected to be not as advanced cases and more readily respond to treatment. This figure of 14 per cent who were housebound can be compared with 14.2 per cent with cerebral paralysis and 7 per cent with hypertensive cardiovascular disease, these three diagnoses being the major cause of this disability.

Homebound patients are as much in need of a full, integrated program of drugs and rehabilitation as that prescribed for ambulatory patients. Too frequently, however, the physician is unable to adequately care for these patients because of lack of facilities in the community or because there is no means through which the various services can be brought to the patient. Ideally, the care of any patient severely handicapped with arthritis should consist of a team† under the control of the patient's physician. A physician can and

1951 ARTHRITIC RECIPIENTS OF AID TO THE DISABLED

	Per Cent
Proportion of total number of recipients	10
Proportion of those requiring one or more personal services in essential activities of daily living	12½
Proportion of those who were housebound	14
Proportion of those who were bedridden	16½
Proportion of those who were chairfast	17

*Read by invitation before the Annual Meeting of The Medical Society of New Jersey, May 1, 1957 in Atlantic City. The author is Associate Medical Director of the Arthritis and Rheumatism Foundation.

1. Summary of Statistical Data for 1956. Canadian Arthritis and Rheumatism Society, B. C. Division.

2. Characteristics of Recipients of Aid to the Permanently and Totally Disabled, Mid-1951 Public Assistance Report No. 22; U. S. Dept of Health, Education and Welfare, April 1953.

†The team should include a physiotherapist, an occupational therapist, a social worker, special nurses or attendants, a consultant when needed by the attending physician, and such additional ancillary services as a psychologist, dietitian, and so forth, as required.

often does combine all of these services within himself. On many occasions, however, a much more efficient treatment program can be obtained by using one or more members of this team.†

Following is a composite picture of a home treatment program drawn in great part from my own experience. Such a program can be modified, reduced or expanded to suit the needs of the community. No two programs are ever exactly the same.

TYPE OF PATIENT

THE home treatment program for the arthritic patient should include not only those who are confined to their own homes but also those in nursing homes, convalescent hospitals, long term hospitals, and so forth, where adequate facilities are not otherwise available. Usually these patients are severely handicapped by their disease. In most cases, however, the disease is inactive and the disabilities relatively constant. The types of patients treated under such a program include those with any of the arthritic or rheumatic diseases. Similarly all age groups are represented. In most instances the age group above 50 predominates but the young adult, adolescent and childhood groups are well represented. No reliable statistics are available on age distribution.

AIMS

THE aim of a home treatment program is to help the patient to learn to become as self-sufficient as possible within the limitations of his disease. Not infrequently much of the disability of these patients is imposed upon them by their environment rather than the disease itself.

In some cases the aims may be very limited, such as to develop the patient's ability to feed himself. In others, less severely handicapped, the aim may be eventual ability to attend a rehabilitation center for more intensive and extensive training and treatment.

Achieving the goals in most patients usually takes months, not days. Once the goals are reached, the patient must receive some supervision in order that the gain be maintained. There is no patient so severely affected that treatment will not improve. However, in most home treatment programs, limitation of staff and funds will markedly restrict the aims for those very severely afflicted.

PHYSIOTHERAPY

THE physiotherapist is the member of the rehabilitation team whom the physician calls upon the most. It is not the function of this worker to utilize a large mass of complicated equipment in the home. The therapist's task is to instruct the patient and the family in ways by which the patient can help himself. For this function, a relatively small amount of simple equipment is required. In the main, this will consist of such demonstration units as simple wax baths for the home (double boiler), Sayr sling, various pulleys and slings, and adjustable crutches. Frequently some form of heat such as a portable infra-red lamp or hydrocollator is included although the patient should have applied heat in preparation for the therapist's visit. Portable short-wave units are not advocated since the amount of good which they might do does not compensate for their trouble.

Under the guidance of the physician, the therapist will assess the patient, then teach and supervise therapeutic exercises and procedures. These usually are not complicated and are outlined in the booklet *Home Care of Rheumatoid Arthritis*.[3]

Visits by the therapist are usually not required more than once or twice a week at first, becoming less frequent as time goes on. However, supervision of the patient must be maintained for a prolonged period and a review of the aims, accomplishments, and program should be made with the physician every three months.

3. *Home Care of Rheumatoid Arthritis.* Medical and Scientific Committee, The Arthritis and Rheumatism Foundation.

OCCUPATIONAL THERAPY

In some problem cases, the occupational therapist can offer a great deal to the successful treatment of the homebound case. Among his functions is the assessment of the activities of daily living of the patient. Following this the occupational therapist devises means by which these may be improved with use of "trick movements," individually tailored self-help devices, and other projects. The occupational therapist will also assess the home and advise on how it may be adapted in order that the homebound become more efficient and self-reliant. Much of this type of treatment for the arthritic has been described by Dr. Edward Lowman in *Self-Help Devices for the Arthritic*[4] and through the publications of the Self-Help Device Center maintained by the Arthritis and Rheumatism Foundation.

One of the other functions of the occupational therapist is to develop tasks like weaving and basket making, tasks at which muscular strength and range of motion are increased.

Although the rewards are great, in general, the case load of an occupational therapist on a home treatment program must be much smaller than that of a physiotherapist because of the increased time and supervision required.

SPECIAL NURSING SERVICE

The physician may frequently obtain help from certain activities not normally performed by the Visiting Nurses Association. A nurse can be trained to apply simple resting casts or splints for the hands, wrists, and lower extremities in homes, and nursing homes under circumstances where it would be difficult for the individual physician to do so. Used in conjuction with physiotherapy and occupational therapy, such splints can do much to overcome many flexion deformities. Nurses can also be trained to give gold to the homebound, observe for toxic signs and collect and transport blood, urine and other specimens to the laboratory. This, in effect, allows the physician to keep a much closer control on his homebound patients than might otherwise be possible.

SOCIAL WORKER

Patients severely handicapped by arthritic diseases are not infrequently under a great deal of personal, environmental and emotional stress which may have an adverse effect upon any attempt at adequate treatment. Such patients obviously need sympathetic counseling and understanding. This usually requires more time than the physician can possibly give. To fill this gap is one function of the medical social worker. These workers by dealing with the emotional and environmental problems of the patient on a relatively superficial level can, in time, achieve great success. With their help, the physician can frequently get results which would have been impossible otherwise.

THE CONSULTANT

For the vast majority of patients with arthritis, the physician can take care of and supervise all aspects of their treatment. However, everyone at times would like the opinion of a consultant, perhaps in physiatry, internal medicine, orthopedics, or some other specialty. This may be needed for patients who would be unable to obtain this service because of being homebound and medically indigent. Such a service should be available at the physician's request.

OTHER SERVICES

A number of other services should be available in order that the patient may be more self-sufficient and also brought back into society. Chief among these may be mentioned

4. Lowman, Edward W.: *Rehabilitation Monograph VI—Self-Help for the Arthritic*, 1954. Institute of Physical Medicine, New York University, Bellevue Medical Center.

the services of a homemaker, either paid or voluntary, and an arts and crafts program. This latter is of great value on a social level not only in reawakening the patient's interest in his surroundings, but also in some cases providing a degree of income. This is particularly important for the male patient with restricted interest. The program can in a large part be run by volunteers and usually requires little or no supervision by the physician.

HOME TREATMENT UNIT

THERE are various ways by which the services of the home treatment team can be made available to physicians. In areas in which existing facilities are inadequate or poorly organized, it is not uncommon for the local chapter of the Arthritis and Rheumatism Foundation to set up and maintain such teams under its own control. In other areas, arrangements are made whereby the local hospital, rehabilitation unit or other facility is subsidized by the Arthritis and Rheumatism Foundation Chapter to provide the personnel for the home visiting team.

In some areas, physiotherapy is obtained through the Visiting Nurses Association. Under these circumstances, not infrequently, the physiotherapist will go into the home, assess the patient, and outline a program which will be supervised and carried out by the patient's nurse. The therapist will check on the nurse and patient at appropriate intervals. The advantage of such a program is that greater use can be made of the trained personnel. For example, in the Detroit area during 1956, one physical therapist was able to assess and supervise the treatment of some 1,047 homebound patients.

REFERRAL OF PATIENTS

THE services of the home visiting team are primarily for the benefit of the practicing physician in order that he may provide an integrated, well rounded treatment program for his homebound arthritic patient. No patient is provided with service, therefore, unless he is referred by a physician. These services are only a part of the total treatment program being directed by the patient's physician. No patient should be given any type of service for longer than three months without new instructions from the physician.

COMMENT

A WELL developed home treatment program facilitates the physician's ability to provide adequate care for patients confined to their homes because of an arthritic or rheumatic disease. Such a program should, ideally, include the service of a physiotherapist, occupational therapist, nurse, social worker, consultants, and auxiliary services. Much can be done for this type of patient to improve his ability to function more adequately in the home or society in general. Such patients do not necessarily need continuous treatment or services. Over half of these patients should require frequent active care of a year or less before they are improved to the point of minimum supervision.

23 West 45 Street

New Cardiology Governor

The American College of Cardiology announces the election of Arthur Bernstein, M.D., as Governor of the College for the state of New Jersey. Dr. Bernstein is a member of The Medical Society of New Jersey.

Irvin Sussman, M.D.

Bridgeton

Hypothyroidism: Diagnostic Implications*

Ever think of hypothyroidism in patients with weakness, and other vague symptoms? It's worth thinking about. Dr. Sussman here presents 5 cases where the wrong diagnosis was first made—and understandably so. Treatment is usually successful.

The diagnosis of hypothyroidism may be easily missed in the clinical practice of medicine. Yet the disease is amenable to simple therapeutic measures, so that general practitioners should be alert to the possibility. This paper reviews some aspects of diagnosis with particular emphasis on the variability of the initial presenting symptoms.

The following case histories are illustrative. Only pertinent points in the history will be outlined.

CASE ONE

A 53-year old married female was first seen with the following complaints: looseness of the bowels, loss of appetite, constipation alternating with diarrhea and considerable worry about her youngest daughter who had moved in with her, six weeks before.

Nausea, vomiting, diarrhea, light-headedness and loss of appetite were first noted one year ago. Two years ago, her eyes became itchy and puffy. She had frequency of urination. She had been told of an enlarged liver and poor circulation of blood. She always felt tired. She had a definite aversion to butter, fried, greasy and rich foods and ice cream.

She had been hospitalized three times for treatment of the "change of life." At the age of 47, her "uterus was taken out." One son was a suicide at the age of 26.

She was 4 feet, 10 inches tall and weighed 137 pounds. Her tongue was dry and coated. Her face appeared puffy, her skin dry, and her hair coarse. Her general appearance was somewhat disheveled. Blood pressure was 150/100. Heart sounds were normal and lungs were clear. Some tenderness was present at the right costovertebral angle.

Hemoglobin was 11.6 Grams. Red cell count was 3,900,000. Barium enema, gall bladder series and chest x-ray were normal.

On the basis of these findings, treatment was directed primarily toward a psychosomatic disturbance. On the next two office visits during the following three weeks, the patient was somewhat improved on symptomatic therapy but she still remained tired with loss of appetite. Diarrhea persisted and was associated with excitement. Her eyes remained puffy in the morning. She found it very difficult to keep warm during the winter. Attention was paid to the speech which was quite halting. The patient stated that her tongue was often "thick" and she could not pronounce words easily. She never sweated. Even excess talking would tire her. At this time an endocrine disturbance was suspected. Basal metabolic rate was minus 23 per cent. Cholesterol was 342 milligrams per cent.

Thyroid extract ¼ grain daily was started and increased to ½ grain twice a day by the second week. Within one month after initiation of therapy she began to show marked improvement in her general appearance. Metabolic rate was minus 12 per cent and cholesterol was 230. The electrocardiogram which initially disclosed low voltage QRS complexes and T waves returned to normal voltage on a repeat tracing two months after initiation of thyroid medication.

The patient is currently doing well. Her maintenance dose of thyroid extract is 2 grains daily. Although she was a typical case of myxedema, the diagnosis was not suspected until

*Read April 30, 1957, at the Annual Meeting of The Medical Society of New Jersey.

the third visit at which time appropriate laboratory studies established the diagnosis. Had the diagnosis been kept in mind at her first visit, it would have been clinically apparent at that time despite her presenting complaints which seemed to point to a gastro-intestinal or psychosomatic disorder.

CASE TWO

A 55-year old married woman was first seen with a chief complaint of "I can't eat or sleep." She had "distress in the face" and in the pit of the stomach when eating. Present illness began with onset of the menopause at the age of 40. Vague aches and complaints had persisted since that time. In the past 4 years these had become worse. She had always been restless. She had been told of anemia and had been constipated all her life. Description of all her complaints were vague. In response to specific questioning, she reported an absence of sweating. Her hair started to fall out at the age of 50. She used to have considerable swelling under her eyes.

Within the past two years she had been a patient at a general hospital, a nursing home and finally at a state mental institution. At this last hospital she was discharged with a final diagnosis of "involutional psychotic reaction." It was reported there that she had had a "prepsychotic psychoneurosis" for an unknown number of years.

She was a well developed, poorly nourished woman with halting speech and paucity of facial expression. The outer third of the eyebrows was sparse. Skin tone and elasticity were poor. Pallor was present. Neurologic examination was negative. Blood pressure was 98/64. The remainder of the examination was negative.

Hemoglobin was 11.0 Grams. Red cell count was 3,800,000. Mazzini was negative. Blood cholesterol was 495. Basal metabolic rate was minus 20 per cent. Electrocardiogram revealed low voltage QRS complexes and T waves throughout the tracing.

Thyroid medication was instituted cautiously, starting with ¼ grain daily for three days and increasing to ½ grain daily for the next three days, 1 grain daily for the following week and subsequent to that 1 grain twice a day.

She showed a remarkable generalized improvement. Metabolic rate remained at minus 20 per cent but cholesterol dropped to 192. Prior to the institution of therapy, she had been bedfast. Although she still complained of a few minor vague symptoms she was able to conduct herself properly around the home and take interest in other activities. Maintenance thyroid medication was established at 1 grain three times a day.

"Myxedema madness" is a well recognized entity. This patient illustrates such an instance where appropriate medication resulted in improvement in the mental picture as well as correction of the physical abnormalities.

CASE THREE

An 11-year old girl was first seen with chief complaints of "a cold for the past week, frequent colds, and she looks pale and run down." The colds would occur usually in the spring and fall. This seasonal incidence had been noted for the past three years. She sneezed when she went near flowers. Appetite had been poor for the past year and she was not quite as "peppy" as she had been.

She was 4 feet, 6 inches tall and weighed 70 pounds. She appeared quite pale. Fullness of the thyroid was noted. The features and hair were coarse. Blood pressure was 80/60. The heart sounds were normal and the lungs were clear.

On the basis of the symptoms and the appearance of the patient, it was decided to investigate for an allergy, endocrine disturbance and possible blood dyscrasia.

Skin tests for epidermals, dust, feathers, pollens and molds were all negative. Hemoglobin was 12.5 Grams. Red cell count was 4,000,000. Urinalysis and differential count were normal. Basal metabolic rate was minus 37 per cent. Blood cholesterol was 344 milligrams per cent.

Thyroid extract was started in dosage of 1 grain daily for one week and then increased to 1 grain twice a day thereafter. Metabolism rose to plus 1 per cent and cholesterol fell to 138 after two months of treatment.

Her response to therapy is also reflected in an excerpt from a letter written by her father, "Let's don't overdo this thing. Our food bills are up 25 per cent already and the kid is wearing me out."

The initial presenting symptoms suggested an allergy. However, although she had no specific allergic therapy, her allergy-like symptoms cleared up completely with thyroid medication alone.

CASE FOUR

A 26-year old married woman suffered from dizzy spells, poor appetite, lack of ambition and "nervousness." These complaints had been present for several years. With her dizzy spells "everything went black." She was in the sixth month of pregnancy. She sweated very little and had a definite preference for warm weather. Constipation had been noted for only the past three weeks.

Before pregnancy, her periods were irregular and would occur at 28 to 45 day intervals and ranged from 7 to 21 days in duration.

She was 5 feet, 5 inches tall, weighed 93 pounds, and was a pallid, thin female. Speech was deliberate and halting and skin was very dry. There was a sparseness of the eyebrows over the outer third. The hair was coarse. The chest was clear to percussion and auscultation. Blood pressure was 100/70. Abdomen was negative except for the expected findings in a six-month pregnancy.

Hemoglobin was 8.0 Grams. Red cell count was 2,750,000. Basal metabolic rate was minus 21 per cent. Blood cholesterol was 419.

Thyroid extract was started in dosage of ½ grain daily for one week and then increased to 1 grain daily for the next three weeks.

She progressively improved. Appetite increased and she had more "ambition." Speech returned to normal. The patient was delivered of a normal male child without difficulty.

This patient represents a case of hypothyroidism associated with pregnancy with considerable improvement in symptoms during the course of pregnancy. Although there is some coarsening of the features during pregnancy, these were improved subsequent to the administration of thyroid extract. There may be some confusion in differentiating which effects are due to the pregnancy and which are due to the hypothyroidism. However, with a suspicion of hypothyroidism based on clinical manifestations, the laboratory studies should clarify the diagnosis.

CASE FIVE

A 58-year old woman was first seen in the hospital in acute *extremis*. Her temperature was 95. Pulse was 40. She was in shock with pinpoint pupils. At a physician's office that afternoon, she had severe chest pain and was given ⅛ grain of morphine sulfate. There was prompt deterioration in the patient's physical appearance precipitating her admission to the hospital. The shock was treated with blood transfusions and the effects of the morphine were counteracted with Nalorphine.*

The following information was obtained the next day when the patient was more responsive. A recent loss of hair had been noted in the past two years. Her speech was slow and her voice was deep. Weakness was prominent. She had been treated for "anemia" for four years. Sparseness was noted in the outer third of the eyebrows. Hypotension had always been present with a systolic pressure under 100. Cardiomegaly had been noted on previous studies. The EKG showed low voltage QRS complexes and T waves and ST segment changes of nonspecific myocardial abnormality.

Hemoglobin was 8.5 Grams. Red cell count was 2,900,000. Basal metabolic rate was minus 9 per cent. Blood cholesterol was 360.

Thyroid extract was cautiously started with ¼ grain daily for the first two days, increasing to ¼ grain twice a day for the next three days and then ½ grain twice a day. The patient was discharged considerably improved.

The sensitivity of hypothyroid patients to morphine was dramatically illustrated by this patient. This case also demonstrates how the diagnosis of hypothyroidism also enters into the differential diagnosis of the comatose patient.

DISCUSSION

MANY factors account for the ease with which this diagnosis may be overlooked. Hypofunction of the thyroid may range from the mildest subclinical pattern to the full blown typical myxedematous patient. The character and severity of the symptoms may vary accordingly. Symptoms may follow no specific or logical pattern making early diagnosis even more difficult and time consuming. In an active general medical practice, the presenting complaints may appear to have no relation to an underlying endocrine disturbance.

The disease is frequently insidious with gradual development of vague and seemingly unrelated symptoms. In obtaining the history some of the more characteristic symptoms such as lack of sweating, intolerance to cold and falling hair are elicited only by direct questioning. The patient may be unaware of these symptoms until attention is directed toward them.

The disease is most often found in middle-aged women. It is easy to attribute the vague symptoms of hypothyroidism to a menopausal syndrome or even a psychosomatic disorder.

It may well be that the most important aid in the early diagnosis of hypothyroidism is to think of the possibility.

SUMMARY

1. Hypothyroidism is a clinical disorder with protean presenting syndromes sometimes obscuring the underlying disease.

2. Five patients are presented to illustrate some of the variability of these presenting manifestations. Differential diagnostic considerations in these patients included menopausal syndrome, psychosomatic gastro-intestinal disorder, involutional melancholia, allergic rhinitis, blood dyscrasia, pregnancy and coma.

3. Because hypothyroidism is so amenable to simple therapy with striking results, the practitioner should keep this possibility in mind.

*We used the Sharp and Dohme brand tradenamed Nalline®.

151 West Commerce Street

Gene L. D'Alessandro, M.D.

Rolf Vlatten, M.D.

Newark

Cardiac Arrhythmias During Intubation*

Rapid anesthesia induction is becoming fashionable. When combined with intubation this may produce electrocardiographic changes. Dr. D'Alessandro and Dr. Vlatten here study the significance of these changes in heart physiology. Their conclusion: the changes are usually not significant.

Electrocardiographic changes during intubation have been studied and discussed by various authors. The recent practice of subjecting patients to a fast induction and intubation made it desirable to study the cardiac effects under those conditions in a group of one hundred patients. Thus, Burstein[1] has reported the high incidence of electrocardiographic changes with many of the different combination of agents and technics used today. And Reid[2] has shown that irritation of the respiratory tract by endotracheal tube may be followed by a reflex effect upon the heart.

It has been stated[3] that 'a gradual, deliberate, smooth saturation of a patient with the lowest effective concentration of an anesthetic drug causes less physiologic imbalance than what is often referred to as the 'blitz" technic.'

Recent advances in anesthesia and the constant demands to reduce anesthesia induction time in the busy operating room, have led to the practice of subjecting patients to a fast induction and intubation using intravenous barbiturate and a relaxing drug. The cardiac effects of this procedure in the patient with a normal or abnormal heart have become very important. An evaluation of these effects, during the following technic has been the object for our study.

A group of one hundred patients were subjected to intubation. The youngest patient was 13 years, and the oldest patient was 84. Most were above the age of 40. All received preoperative atropine and morphine sulfate according to weight and general condition 45 minutes before the induction of anesthesia.

The anesthesia was induced with 2 per cent sodium thiopental.† After a test dose of 3 cubic centimeters, 7 cubic centimeters of sodium thiopental were injected rather rapidly. This was followed by succinylcholine chloride§ in an amount which in milligrams equalled ¼ of the patient's body weight in pounds. Maximum dose was 50 milligrams. The succinylcholine chloride§ was injected slowly to avoid excessive muscle twitching and was followed by 10 cubic centimeters of 2 per cent sodium thiopental† making the total amount of the thiopental† in each case 20 cubic centimeters (400 milligrams). By this technic, it was cer-

*Read May 1, 1957 before the Anesthesiology Section of The Medical Society of New Jersey. This work is from the Newark (N.J.) Presbyterian Hospital.

†Under the Abbott trade name of Pentothal®.

§Under the Burroughs Wellcome trade name of Anectine®.

1. Burstein, C. L., LoPinto, F. J. and Newman, W.: Anesthesiology, 11:224 (March 1950)

2. Reid, L. C. and Brace, D. E.: Surg. Gyn. Obs., 70:157 (Feb. 1940)

3. Bennett, W. D. and Davis, M., Jr.: Anesthesiology, 13:117 (January, 1952)

tain that the total calculated amount of succinylcholine chloride was in circulation before intubation was attempted. During the injection, the patient's chin was supported, but no mechanical airway was used and no oxygen was administered. Relaxation was present 20 to 60 seconds after completion of the injection. Intubation was attempted at the earliest possible moment of maximum relaxation, and soft rubber endotracheal airway of the largest size feasible was passed.

Electrocardiogram recordings, 3 standard and 3 unipolar limb leads were taken of all patients pre-operatively. Subsequent recordings of lead 2 were taken after completion of thiopental succinylcholine chloride injection, during laryngoscopy and continuously during and after intubation until a stabilized electrocardiogram was recognized on the cardioscope. These examinations were done with an operating room cardioscope, and permanent records obtained in each case. After the intubation, the cardioscope was observed closely for possible developing changes before surgical procedure or depth of anesthesia altered the recording.

Fifty of the 100 patients were subjected solely to the procedure described above. The other fifty received, by spray, a topical application of 5 per cent hexylcaine. In each group, pre-operative electrocardiograms were obtained. Before induction of anesthesia, the patient's pharynx and larynx were thoroughly sprayed with hexylcaine.‡ The epiglottis and cords were exposed and sprayed with a liberal amount of solution so that some of the hexylcaine drained into the trachea. An electrocardiogram tracing, lead 2, was obtained after the patient had come to rest. Three to five minutes after the topical anesthesia was completed, general anesthesia was induced and intubation attempted under electrocardiographic control in the technic used in the first 50 patients. Ninety of the intubations were done by one person, to exclude the possible variation in technic and skill. The same person recorded at the time of intubation his impression as to the difficulty under which intubation was accomplished.

Intubation could be successfully performed in the manner described in 98 out of the 100 cases. In two cases, intubation was attempted but given up when technical difficulties or electrocardiographic changes were considered serious enough to abolish the attempt. The relaxation after the Pentothal® succinylcholine chloride injection was satisfactory in all cases. Difficulties encountered in intubation were due to anatomic variations.

RESULTS

THE electrocardiographic records of 100 patients were examined. The changes are displayed in Table 1. While the number seems high, they all reverted to the pre-operative rhythm in less than five minutes and no deleterious effects were noted postoperatively.

TABLE 1. ELECTROCARDIOGRAPHIC CHANGES DURING INTUBATION
100 PATIENTS

Increased cardiac rate	73%
Depression of T wave	61%
Depression of St segment	43%
Supraventricular tachycardia	45%
Arrhythmias	22%
Electrocardiographic changes	59%

We next examined the electrocardiographic records of patients intubated with and without topical anesthesia. See Table 2. There were no significant differences in cardiac rate between the two groups. However, patients with topical anesthesia showed a greater incidence of depression of T wave, St segment, supraventricular tachycardia and twice as many arrhythmias than the group intubated without topical anesthesia.

TABLE 2. ELECTROCARDIOGRAPHIC CHANGES DURING INTUBATION

Group 1 with topical (50 patients)
Group 2 without topical (50 patients)

	Group 1	Group 2
Increased cardiac rate	39 pts.	34 pts.
Decreased cardiac rate	7 pts.	10 pts.
Depression of T wave	38 pts.	23 pts.
Depression of ST segment	24 pts.	19 pts.
Supraventricular tachycardia	26 pts.	19 pts.
Arrhythmias	15 pts.	7 pts.

‡ Administered under the Sharp and Dohme tradename of Cycaine®.

An attempt was made to determine during what phase of this anesthetic technic most of the changes took place. In both groups, supraventricular tachycardia and depression of T wave and St segment occurred most often after the thiopental-succinylcholine induction rather than at the time of laryngoscopy or intubation. However, the arrhythmias, although they have been observed at the time of intubation, occurred most often 2 to 30 seconds after the tube was inserted. See Table 3.

TABLE 3. SUPRAVENTRICULAR TACHYCARDIA

	With Topical	Without Topical
After spray	5	
After thiop-succ.	13	11
Laryngoscopy	3	6
Intubation	5	2
	26	19

Electrocardiographic records of patients with myocardial disease before anesthesia are summarized in Table 4.

TABLE 4. ECG CHANGES IN PATIENTS WITH MYOCARDIAL DAMAGE

	Normal Patients(75)	Myocardial(25)
Arrhythmias	16%	40%
Supraventricular tachycardia	48%	55%
Depression of T wave	24%	52%

The arrhythmias were 2½ times as frequent in patients with previous myocardial damage. There were also a greater number of supraventricular tachycardias in these patients. Depression of T wave occurred twice as often.

In this series of 100 patients intubated, there were, as shown in Table 5, twenty-two difficult intubations. The difficult intubations produced a great number of electrocardiographic changes. Arrhythmias occurred twice as often while supraventricular tachycardia occurred 1½ times as often in the difficult intubation as it did in the easy ones. However, although many electrocardiographic changes occurred during this study, most of them were not considered significant. These changes were all transient and lasted for less than five minutes. The changes that *were* significant were the arrhythmias that occurred in 22 per cent of the patients. Of these 22 patients, ten showed electrocardiographic changes that could develop into something very serious. These were the late premature ventricular contractions which may be the forerunner of ventricular tachycardia or ventricular fibrillation.

TABLE 5. ECG CHANGES DURING DIFFICULT INTUBATION

	Difficult	Easy
Arrhythmias	36%	18%
Supraventricular tachycardia	59%	41%

COMMENT

ELECTROCARDIOGRAPHIC changes that occur during the process of anesthesia and intubation may be caused by many factors such as hypoxia, hypercapnea, reflex stimulation, pharmacologic effect of drugs used and intrinsic heart disease. The effects of anoxia on the normal electrocardiogram frequently observed are increased heart rate, decreased and inverted T wave and RST segment displacement. Bradycardia, arrhythmias and conduction disturbances are believed to be a reaction to anoxia with increased vagal tone.[4] Anoxia as well as vagal reflex can cause bradycardia and atrio-ventricular block.[5] It has been stated that cardiac disturbances during intubation are rare in the absence of hypoxia.[3] Mechanical stimulation of the tracheobronchial tree produced delayed conduction time, bradycardia and extrasystoles. These changes are thought to be vago-vagal reflex effect.[2] The most frequent electrocardiographic changes during intubation were sinus tachycardia which points to the cardiac accelerator fibers as being the reflex mechanism producing these changes. If hypoxia and hypercapnea can be ruled out during intubation, then these changes may be of reflex origin.

4. Steward, H. J. and Carr, H. A.: American Heart Journal, 48:293 (August 1954)

5. Campbell, M. and Reynolds, G.: British Heart Journal, 16:57 (January 1954)

There is little evidence in our series of vagal slowing of the heart. After the thiopental induction, the heart rate increased in most of our patients, regardless of whether induction was preceded by topical anesthesia. There was no evidence of increased vagal tone; at least there were no prolongations of the atrioventricular or intraventricular conduction. Even in cases where the heart rate decreased, a sinus bradycardia was never observed. The most striking finding in this series was the high incidence of sinus tachycardia. This indicates that the cardio-accelerator nerves dominate during the period of intubation. It is not clear whether this is a direct stimulation of cardio-accelerator reflexes or due to increased vagotonus with overbalanced sympathetic system. However, it is significant that supraventricular tachycardia occurred more frequently after the administration of the anesthetic drugs and before intubation.

The pharmacologic effects of the anesthetic drugs used during intubation are very important. It has been stated [6] that even an overdosage of Pentothal® should not cause cardiac arrhythmias.

Intrinsic heart disease may alter the patient's threshold of reaction to any or all of these factors.[7] Patients with evidence of myocardial disease in this series have had much greater incidence of electrocardiographic changes.

SUMMARY

1. A fast intubation method with thiopental-succinylcholine chloride was studied in one hundred patients. Electrocardiographic changes occurred in 59 of these 100 subjects.

2. The use of topical anesthesia before intubation produced a greater number of changes.

3. Supraventricular tachycardia, depression of T wave and St segment occurred most frequently after the anesthetic induction.

4. Arrhythmias occurred 2 to 30 seconds after the insertion of the catheter and were probably due to reflex stimulation.

5. Patients with pre-operative evidence of myocardial damage had 2½ times as many arrhythmias than the normal patients.

6. Difficult intubations produced twice as many arrhythmias and 1½ times as many supraventricular tachycardias. This was probably of hypoxic origin and periods of oxygenation should be instituted in all difficult intubations.

CONCLUSIONS

1. The electrocardiographic changes resulting from a fast induction and intubation with thiopental-sodium and succinylcholine chloride are of a benign nature in most cases. Many of the changes occurred after the administration of the anesthetic agents and before the intubation.

2. Arrhythmias occurred in 22 of the patients. These were the only changes of any great significance. In this group there were 10 cases of late premature ventricular extrasystoles. They frequently occurred in bigeminal rhythm and led in some cases to complex arrhythmias. Late premature ventricular extrasystoles could become very serious and be the beginning of ventricular tachycardia and ventricular fibrillation. They are unusual in patients with normal hearts and may explain the reason for cardiac arrest in these individuals.

3. The arrhythmias occurred 2 to 30 seconds after the insertion of the catheter and were more common in the patients with evidence of myocardial disease, topical anesthesia and in difficult intubations.

4. All the electrocardiographic changes recorded in this series were of a transitory nature lasting from a few seconds to five minutes. No deleterious effects were noted postoperatively.

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Tampon Technic for Mass Cytologic Screening*

If the key to cancer control is to be mass screening, then a swift and workable method must be found for such screening in all types of cancer. For carcinoma of the cervix the tampon method appears to be the most desirable, in spite of certain limitations which the authors here point out.

Brunschwig[1] in 1954 first reported the use of vaginal tampons(devised by Draghi) as a means of obtaining material for the cytologic examination of secretions from the female genital tract. Both he and Papanicolaou,[3] who studied the smears, suggested that the tampon might be a valuable method for mass screening of large numbers of patients.

The purpose of the study here reported was to determine the practical value of the vaginal tampon in any prospective mass screening program. It seemed essential that deliberate selection of cases be avoided. Unselected patients in the routine office practice of two clinicians were used. This provided statistically significant data indicating whether this technic could be successfully applied to mass screening.

No special effort was made to evaluate the method for its diagnostic accuracy. This has been studied previously and seemed to be reasonably well established.[2,3,6] Rather, we sought to determine: (1) The acceptability of this modality by the patients. (2) The clinician's evaluation of the technic to determine whether it would encourage more extensive use of screening. (3) The technical adequacy of the smears for cytologic study, and (4) The applicability of the modality to mass screening in the light of the patient's reaction, the clinician's impressions, and the laboratory evaluation.

MATERIALS AND METHODS

Three hundred and forty unselected females encountered in the routine office practice of two clinicians were used. In the first 172 women, vaginal aspiration smears were made by the doctors in accordance with the methods recommended by Papanicolaou.[4] Tampons devised by Draghi† were then issued to these patients with written instructions as to the method of insertion of the tampon as well as proper making of smears from the tampon. This provided the opportunity to compare routine aspiration smears with tampon smears from the same patients. About one-half of these 172 women returned after the tampon

*This work was done in cooperation with the Cancer Bureau of the Division of Chronic Illness, New Jersey State Department of Health.

†Supplied by Tampax Corporation, courtesy of Dr. Draghi.

had been in place overnight. Smears were then made by the doctor or his office nurse. The others made their own smears. In the remaining 158 cases, the tampon technic alone was used. In view of the results obtained in the original 172 cases, three changes were made in reference to this second group of cases: (1) Longer tampons were used to obtain closer apposition to the cervix; (2) revised written instructions were issued based on sources of error discovered in the first group of cases; and (3) the method of smearing with the tampon was changed to correct technical inadequacies noted in the first series of slides. All smears were immediately placed in equal parts of ether and 95 per cent ethyl alcohol. The smears were examined by a technician trained in the Papanicolaou technic. Results were checked by a pathologist. The smears were classified in accordance with Papanicolaou's recommendations.[7] They were evaluated for excellence of preparation, as well as for their histologic value for purposes of classification.

RESULTS

THE tampon technic was accepted by most of the patients. A few were alarmed by the procedure because they felt that the doctor suspected pathology in the genital tract. These same women accepted, without apprehension, vaginal aspirations done during the routine office visit as part of the general examination. A second group were those with anatomic impediments. Those with senile vaginal changes found insertion of the tampon difficult or impossible. Upon withdrawal, slight bleeding occurred in some and gave rise to undue apprehension. A few with procidentia, had difficulty in retaining the tampon. Other patients, particularly those in the older age groups, were completely unfamiliar with the use of tampons and objected to them because of this. A small number rejected the tampon on esthetic grounds. In view of these clinical findings, it would seem wise to select carefully or eliminate entirely women like these from any mass screening program.

While the tampon technic met the approval of the two clinicians, they felt that aspiration was preferable to the tampon method in respect to time saving in a busy practice. Their main objection to the tampons lay in the detailed instructions necessary for proper results. If an office nurse was not available, this was a serious objection timewise. The chief advantages of the tampon method from the clinical point of view were: (1) If the patients had taken a douche before the office visit, the volume of vaginal aspirate was likely to be minimal; issuance of a tampon would then preclude an extra office visit. (2) In some cases, the vaginal tract had been contaminated by lubricants used in the bimanual examination. Since this often led to poor aspiration smears, the tampon resulted in better histologic material. (3) Some patients specifically requested a cytologic study at the completion of the office visit when the physical examination had already been done. In these cases, the tampon technic was preferable to re-examining the patient in order to obtain the aspiration smears. (4) There were instances in which repeated cytology studies were indicated either for diagnostic purposes or after therapy. Obviously, in these cases, the use of tampons was especially helpful. There was a saving of time for the doctor in that the task of explaining the procedure and issuing the necessary instructions and materials did not need to be repeated after the initial visit. It was found that tampon smears could be adequately made by the patient.

Study of the slides revealed that both aspiration and tampon smears were technically satisfactory in 71 per cent of the cases (see Table 1). If the slides were studied as un-

TABLE 1.

SMEARS OBTAINED BY ASPIRATION AND BY TAMPON
GROUP I (172 Patients)

Type of Collection and Result of Smears	Cases	
	Number	Per Cent
Aspiration and tampon, both slides satisfactory	122	71
Aspiration, slide satisfactory; tampon, slide unsatisfactory	47	27
Aspiration, slide unsatisfactory; tampon, slide satisfactory	3	2
TOTAL GROUP I	172	100.0

knowns, it was difficult to tell an aspiration smear from a tampon smear. However, on a comparative basis, the aspiration smears were often more informative than the tampon smears. For example, trichomonads which were obvious in aspirated material did not usually appear in the tampon material. The wide variety of cellular elements noted in vaginal smears was often lacking in the tampon smears. Some of the cells in tampon smears were stretched out or curled. Consequently, in addition to the 27 per cent unsatisfactory tampon smears shown in Table 1, there was a further 13 per cent (for a total of 40 per cent) where the aspiration smears were considered to be distinctly superior in quality. Conversely, tampon smears were superior to aspiration smears in only 2 per cent of the cases. These findings were in accordance with those of Papanicolaou:[3] "The tampon method does not provide as adequate material for cytologic study as a set of vaginal and endocervical smears."

Smears made by the patients were histologically indistinguishable from those made by the doctor or nurse. The same ratio of satisfactory or unsatisfactory smears occurred regardless of who made them. The implications in respect to any prospective large scale program are obvious.

The tampon smears were found unsatisfactory (class 0) in 27 per cent of the 172 cases, whereas only three (2 per cent) of the aspiration smears were given an 0 classification. This latter figure is comparable to the results obtained in routine vaginal aspiration and cervical smears in our laboratory where during the same period, only 30 of 2088 cases were considered class 0 (that is, 1½ per cent). These vaginal aspiration and cervical smears were made on an unselected group of patients by house staff personnel and clinicians not particularly trained in the technic.

Since unsatisfactory tampon smears were obtained in such a high proportion of the original 172 cases, an additional 158 were studied. Only tampon smears were done in this group inasmuch as it was felt that further comparison between the tampon and aspiration smears was not necessary. At this point, the objective was to check the incidence of class 0 tampon smears on further trial. At the same time, it was possible to note the effect of better written instructions and improved smearing technic which evolved from experience with the original group.

Table 2 shows the classification given to these additional 158 smears. There was a 13 per cent increase in the number of satisfactory tampon smears (85 against 72 per cent) with a corresponding decrease in the unsatisfactory group (15 against 28 per cent). This improvement was attributed largely to better instructions and the revised smearing technic. All of these smears were made by the patients, and the results supplemented the original observation that patients are perfectly capable of making their own smears. It was felt that the satisfactory tampon slides were diagnostically adequate for screening purposes.

TABLE 2.

SMEARS OBTAINED BY TAMPON ONLY
GROUP II (158 Patients)

Type of Collection and Result of Smears	Cases	
	Number	Per Cent
Tampon, slide satisfactory	135	85
Tampon, slide unsatisfactory	23	15
TOTAL GROUP II	158	100.0

DISCUSSION

Thornton[6] and Nieburgs[2] have endorsed the tampon method for mass screening. Thornton[6] also used tampons devised by Draghi.† Her subjects were hospital and clinic patients who were supervised by the nursing service until they became familiar with the technic. In this way, patient problems regarding the use of the tampon were solved. However, in any mass screening program of unselected patients, this personal supervision would be impractical if one were, for example, attempting to screen the female personnel of a large industrial organization. Thornton found only 1½ per cent unsatisfactory smears in 2,059 cases which contrasted sharply with our score of 15 per cent. The probable explanation for this lies in the close medical supervision which her subjects received and the fact

that her patients were hospital or clinic cases under study. Our results, on the other hand, were based on a heterogeneous group of women seen routinely in office practice. This seemed to us a more valid way of duplicating conditions which would exist in a mass screening program. It seems likely that the divergence of methods employed in approaching this problem accounts for the disparity in the number of unsatisfactory smears found by Thornton as against those here reported.

Nieburgs[2] used modified Meds® vaginal tampons in thirty patients with known carcinoma of the cervix. The tampon smears resulted in accurate diagnoses in all instances. He suggested that the smears should be made by a doctor or nurse. Our results clearly showed that this was not necessary. Nieburgs[2] felt that the entire female population could be screened by means of the tampon technic. Our data indicated that a majority rather than the "entire" female population were amenable to study by this method. He stated that any mass screening program should be conducted under medical supervision. He did not elucidate as to the type or degree of such supervision. If a physical examination were required, for example, we would favor the vaginal aspiration method for reasons already mentioned. This point was originally established by Papanicolaou.[3] Nieburgs[2] showed that tampon smears provided diagnostic material in selected cases. It is perhaps not entirely warranted to conclude that the method can be applied to *all* unselected cases without regard for clinical and laboratory limitations.

Our experiences with the tampon method indicated that it had limitations which must be taken into account when any mass screening project is contemplated. From the clinical point of view such factors as lack of familiarity with the tampon, involutional vaginal changes, or other physical and emotional factors will eliminate some cases from the study. On the laboratory side, it seems that, at best, 15 per cent of the smears will be histologically unsatisfactory. Thus, for every 100 women examined by the tampon method, 85 could be expected to provide smears adequate for study.

On the other hand, in a mass screening program, the tampons would obviate the need for trained personnel to make smears, the physical equipment required by the aspiration technic, and the inconvenience to the patient incidental to that modality. Furthermore, by the use of visual aids, large numbers of women could be instructed in the use of tampons. This, combined with detailed written instructions, could be expected to result in adequate material in the great majority of cases. The saving of time for the clinician at this initial stage of mass screening is obvious.

SUMMARY

1. The vaginal tampon method of obtaining material for cytologic screening met the approval of both clinician and patient in most instances.

2. Clinically, its limitations included: (1) Those patients with anatomic impediments in the lower genital tract, and (2) Those patients who were unfamiliar with the tampon technic or those who recoiled from the method for esthetic or emotional reasons.

3. Laboratory results showed that patients using the tampon method produced adequate smears in 85 per cent of cases and thus proved the method to be applicable to the majority of unselected patients.

4. Within the clinical and laboratory limitations described, the tampon technic appeared applicable to mass cytologic screening.

We thank Stella Booth, M.D., of the New Jersey State Department of Health for invaluable aid in coordinating this project and Mrs. Hertha Schroeder for her technical assistance.

The Hunterdon Medical Center

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Trustees' Meeting

At its meeting November 17, 1957, the Board of Trustees:

—Discussed the question of lending or giving x-ray films to the New Jersey Workmen's Compensation Bureau, and adopted a suggestion that the radiologist process a second set of films for submission with the report retaining one set for his own files. It also repeated that, in the opinion of the Society's counsel, the films are the property of the physician.

—Pledged cooperation in the State Health Department's epidemiologic study of neoplasms of the lymphatic and hematopoietic systems.

—Adopted a resolution to the effect that "it is the policy of this Society that only persons possessing an unlimited license to practice medicine in this state should be empowered to certify workmen's compensation and other disability cases."

—Received a report from Ocean County Medical Society that a poll of its members on social security for physicians showed 28 in favor, 14 not in favor, 10 no reply.

—Authorized a grant of $10,000 to the American Medical Education Foundation, in keeping with the House of Delegates action at its May 1957 session.

—Instructed the Finance and Budget Committee to consider the advisability of a supplementary $15,000 grant to AMEF.

—Approved the nominations of Dr. John Kimmich to be chairman and Dr. Benjamin Lee to be secretary of the new Section on Preventive Medicine for the 1958 Annual Meeting.

—Approved the schedule of events and sessions for the 1958 Annual Meeting.

—Allocated to the Medical Student Loan Fund the net balance from the Annual Meeting account.

—Received with thanks a donation of $5,000 from the JOURNAL Reserve Account for transfer to the Student Loan Fund.

—Recommended that the Eye Health Screening Program be repeated in future years under the auspices of The Medical Society of New Jersey.

—Approved the report of the Legislative Analyst. See below.

—Authorized Dr. McCall and Dr. Sica to attend the AMA state-societies conference in Philadelphia in December 1957.

—On advice of counsel, authorized the signature of the appropriate officials to the Defense Department's Supplemental Agreement in connection with the Medicare program. And, in this connection, authorized its special committee to renegotiate the contract when it is due for such action in January 1958.

—Reaffirmed its 1955 action approving the proposal of Medical-Surgical Plan to develop one or more supplemental policies in various income levels.

—Accepted the report of the Permanent Committee on Blue Shield with reference to alleged contract inequities.

—Rejected the suggestion by union officials that home care benefits be included in medical, surgical and hospital insurance plans.

—Voiced objection to a proposed change in the Trenton zoning ordinances that would permit the erection of a large apartment house, with adjacent stores and an office building, on property near the Society's headquarters.

—Elected Dr. Levi Walker as Alternate Delegate to the Connecticut Medical Society.

REPORT OF THE LEGISLATIVE ANALYST

CORPORATE PRACTICE OF MEDICINE

This report supplements prior comments concerning the corporate practice of medicine, submitted to the Subcommittee on Legislation

in January, 1956. My comments at that time included an analysis of legislation proposed by the New Jersey Radiological Society, which was drafted by their counsel, Gerald O'Mara.

"Corporate practice of medicine" is prohibited in New Jersey. The issue as it has been presented to the Medical Society is not truly a question of "corporate practice of medicine," which is prohibited by law and fact (R. S. 45:9-22), since only a person licensed to practice medicine and surgery may so practice in this State, and a corporation may not become so licensed; but rather the practice of hospitals' engaging the services of radiologists, pathologists, resident physicians, and others licensed to practice medicine and surgery on a salary basis. This practice is not prohibited by our statutes.

Comments submitted in January, 1956, (Discussion on Corporate Practice of Medicine as Applicable to Radiologists) were directed to ways by which the problem under discussion at that time might be resolved by the radiologists short of legislative action, in addition to the analysis of proposed legislation. It would appear that if the various methods proposed for resolution of the problem short of legislative action have been tried to no avail, the following amendment to the Medical Practice Act, if enacted and properly administered, would be adequate to prevent future hiring of physicians by hospitals and other undesirable practices related to splitting of fees. The person (hospital) who pays a physician a salary from fees collected from its patients and the physician accepting such a salary are in effect splitting fees.

Prohibition of fee splitting could be effected by amending Section 45:9-22 of the Medical Practice Act, which defines and prohibits certain practices as illegal, to prohibit "division of fees or agreeing to split or divide the fees to be received for professional services by any person with any person for bringing or referring a patient or assisting in the care or treatment of a patient." If the principle expressed above is approved, I believe it would be advisable to define "professonal services" as medical or surgical services.

The penalty for violation of such an amendment to the Medical Practice Act should be the same as for any other provision of the Medical Practice Act. If such an amendment is approved, such approval should include mention of the penalty for its violation.

In conclusion, it must be realized that one violation subjects both a person (hospital in most cases) and a physician to a penalty.

EXAMINATION OF HOSPITAL RECORDS

The following comments concerning the resolution of the Middlesex County Medical Society entitled "Examination of Hospital Records" are respectfully submitted for consideration of the Subcommittee on Legislation:

The resolution advocates amendment of the law permitting any person against whom a claim is asserted for personal injuries, or his agent, to examine the records of a hospital concerning the claimant. The resolution recommends amending the law to permit inspection of such records only upon "consent in writing" of the claimant. Such an amendment would in effect repeal existing law. All a claimant need do is to refuse to grant consent in writing and the person sued or his agent would be obliged, as was true before existing law was enacted, to obtain an order of the court permitting review of hospital records. Experience has shown that the Legislature will repeal a law only if it appears that injustice is perpetrated because of that law.

The question arises: What is the injustice here? The *whereas* clauses of the aforementioned resolution conclude:

(a) "Hospital records are indiscriminately examined by unauthorized persons."

Any examination however cursory if performed by an unauthorized person would be improper. Should this fact warrant repeal of the law or would an amendment to the law subjecting such person to fine and imprisonment as a disorderly person be the proper solution to the problem?

(b) "It is imperative for the protection of the patients that this abuse be stopped."

What is the specific danger to the patient from review of his hospital records which should be protected? Is it the common law that a man's person shall be inviolate from the prying eye of his neighbor? Is this such as warrants repeal of a law in effect since 1945, or may the problem be resolved by less drastic legislation as suggested in (a) above? Is the problem one which may be caused by lax hospital administration? Should amendments, as might be drafted, hold the hospital responsible for permitting review of hospital records by "unauthorized persons?"

I do not believe the Legislature would be favorably disposed to the amendment advocated by the Middlesex County Medical Society. Insurance companies can be expected to resist this amendment. However, such an

amendment can be drawn readily if it is concluded that the problem can best be resolved in that manner.

E. POWERS MINCHER

PERMANENT BLUE SHIELD COMMITTEE
Report of Conference held July 30, 1957

Present: For The Medical Society of New Jersey—Dr. Albert B. Kump, Dr. Carl N. Ware, Mr. Richard Nevin; For Medical-Surgical Plan of New Jersey—Dr. Royal A. Schaaf, Mr. John S. Thompson and Dr. Nicholas F. Alfano.

The purpose of this meeting was to study a resolution from the Middlesex County Medical Society on Medical-Surgical Plan "Contract Inequities" which was approved in principle by the House of Delegates at the 1957 Annual Meeting. The Resolution, which was referred to the Trustees of The Medical Society of New Jersey for further study with Medical-Surgical Plan of New Jersey, is as follows:

Whereas, the individual members of The Medical Society of New Jersey have a vital interest in the actual contracts of the Medical-Surgical Plan of New Jersey; and

Whereas, the provisions of the Contracts of the Medical-Surgical Plan of New Jersey exhibit several inequities working to the detriment of both participating physician and the patient; therefore be it

Resolved, that the Middlesex County Component Medical Society demands that the following policy changes be effected by the Medical-Surgical Plan of New Jersey:

1. When the patient has multiple medical-surgical type coverage, either through non-profit or indemnity plans or both, the participating physician shall be entitled to his usual fee or to the value of the total medical-surgical type coverage, whichever is less;
2. Multiple non-profit medical-surgical type coverage, other than duplicate contracts within the same state, shall be allowed;
3. In third party actions the participating physician shall not have his fee restricted by the Medical-Surgical Plan of New Jersey, but shall be entitled to his usual fee or to the combined value of the fee paid by the Medical-Surgical Plan of New Jersey plus any judgment for medical services awarded the patient, whichever is less;
4. When necessary operative and non-operative care is rendered by one or more participating physicians, said operation either incidental to or secondary to the total non-operative care of the patient; the physician or physicians rendering the care shall be entitled to receive both the medical and the surgical fees authorized under the schedule of payments of the Medical-Surgical Plan of New Jersey; and be it further

Resolved, that the Middlesex County Component Medical Society requests that consideration be given by the Medical-Surgical Plan of New Jersey to an increase in its schedule of fees and particularly to an increase in its variety of coverage, similar to that presently in force in neighboring states, where patients in much lower income groups are entitled to a greater variety and degree of coverage.

1. Representatives of Medical-Surgical Plan stated that the question of multiple medical-surgical types of coverage had arisen a number of times in the past. The Plan Subscription Contract, Section VII, relating to when Participating Physicians will accept Plan payment as payment in full, reads as follows:

> Plan payment to a Participating Physician for services under this Contract, except as otherwise provided in this Contract, shall constitute payment in full unless, under a Single Contract, the annual income of the Subscriber is more than five thousand dollars ($5,000) or unless, under a Family Contract, the annual income of the Subscriber (together with that of Subscriber's spouse if enrolled thereunder) is more than seven thousand five hundred dollars ($7,500); said respective incomes to be calculated for the period of the 12 calendar months immediately preceding the month in which the services commenced for which Plan payment is made.

The Plan has had repeated and competent legal opinions that *cash benefits derived from insurance are not considered within the legal classification of "income."* Therefore, proceeds of an insurance benefit would not affect the income status of a subscriber with respect to his eligibility for "service benefits." In discussion of this matter, it was brought out that payment by a liability insurance company for services of a physician rendered by a patient who is also insured by Medical-Surgical Plan, is not necessarily in consideration of same service or obligation as the payment made by the Plan to the physician. Actually from a legal point of view, any settlement made by the insurance company, belongs to the patient and such payment generally refers to other matters than the services of a physician.

Consequently, the position of the Plan under the Contract terms is that if the annual income of the Subscriber at the time services are rendered is such as to entitle him to "service benefits" on the part of a Participating Physician, and if such physician accepts payment from the Plan for his eligible services, then he would not be expected to accept additional payment from any other source for the same services.

2. With respect to payment in cases where the patient has multiple non-profit medical-surgical coverage other than duplicate contracts within the same state, the Medical-Surgical Plan Subscription Contract, Section V(7), relative to services for which the Plan shall not be liable for payment, provides as follows:

> For services, otherwise eligible hereunder, to the extent thereof that payment or reimbursement therefor is eligible under any non-profit hospital service plan and/or non-profit medical and/or non-profit surgical service plan, other than under this Contract.

3. In discussion of third party liability actions, reference was made to a report of a conference held by Plan representatives with the New Jersey Orthopedic Society and the New Jersey Section of the American College of Surgeons with respect to care of accident cases. The question before these groups was whether the Plan should continue to make payment in cases where a third party liability is involved or whether, in a new Subscription Contract, consideration should be given to exclude liability of the Plan in such cases.

Experience indicates that liens filed by hospitals and doctors in public liability cases are satisfied in only a very small proportion of cases. Also, that only in a very small proportion of that minority of cases is the income status of the patient such as to permit the physician to make a charge over and above Plan payment for the professional services covered by the Plan Contract for such of those who were enrolled in Medical-Surgical Plan.

It was the consensus of this conference that it would be better from the standpoint of the medical profession itself for the Plan to continue to make payment in third party liability cases under present contract provisions, which exclude the Participating Physician from making any additional charge where the income status of the Subscriber entitles him to "service benefits." It is better to receive the Plan's scheduled payment for professional services in each such case than to rely on the contingent possibility of a larger payment in perhaps 10 to 20 per cent of such cases through the public liability action which might take years to settle.

In many cases of third party liability action, physicians are called upon to render services not covered by the Plan Contract — to engage in consultation with attorneys, to complete extensive reports, to testify in court, to render treatment outside of hospital following discharge therefrom, etc.—which are not eligible for Plan payment and hence, for which the Participating Physician may reach separate arrangement for compensation for such services with his patient.

4. With respect to benefits, when necessary operative and non-operative care is rendered by one or more physicians, Plan policy is that payment to a physician, for a surgical procedure in surgical cases without complicating medical disease, includes the procedure and post-operative care during the particular hospital admission. Services of the operating surgeon rendered more than 48 hours prior to the day on which surgery is performed, are eligible for payment to the surgeon to the extent as limited in the Subscription Contract for daily medical care rendered up to 48 hours prior to surgery, in addition to payment for the surgical procedure.

If a physician, other than the operating surgeon rendered pre-operative care in hospital prior to the day of surgery, payment to such physician is made for daily medical care to the extent as limited in the Subscription Contract up to the day of surgery.

In a surgical case where there is a complicating medical condition, requiring definitive medical attendance other than routine post-operative care, and treatment for such complicating medical condition is rendered by a physician other than the surgeon, payment to such physician is made for each day of medical care to the extent as defined and limited in the Subscription Contract in addition to payment to the surgeon for the operation and post-operative care.

Payment for routine postoperative care rendered by a Participating Physician other than the Participating surgeon may be made from the total available surgical fee in amounts varying from $10 to $50 depending upon the Plan payment for the particular surgical procedure, when such apportionment is authorized by the Participating surgeon, and when each Participating Physician submits individual reports and charges for his respective services.

With respect to the resolution relative to consideration by Medical-Surgical Plan for an increase in the Schedule of Payments, information was given that the Plan's Fee Committee and a Special Committee of Internists —by direction of the Board of Trustees— are currently reviewing the entire Schedule for adjustment of fees; further, that studies are under way for additional coverage for services which are unavailable under the current Series 1956 Subscription Contract. The additional services will be made available to enrolled Groups by means of riders to the basic contract, without writing a new contract. Tentative approval for offering of riders to the basic

contract has been obtained from the state Department of Banking and Insurance.

Discussion of that part of the resolution which reads . . . "in neighboring states, where patients in much lower income groups are entitled to a greater variety and degree of coverage," followed. It was pointed out by Plan representatives that such a statement is without factual basis and obviously due to a lack of understanding on the part of its originators, for the following reasons: the alleged "greater variety and degree of coverage" in neighboring states only appears to be such because such states are able to sell multiple types of contracts with varying income limits and varying fees for the same service. For example, payment for an appendectomy performed upon a subscriber holding a lower income contract is $125. However, the same operation pays $175 to a subscriber holding a higher income contract. In short, such states are able to apply varying standards of fees for services depending upon the economic status of a particular subscriber. As to the greater variety of coverage, such states are also able to offer "tailor-made" contracts providing whatever benefits are desired by a particular group at a premium rate which is computed accordingly. New Jersey Blue Shield, on the other hand, has but one contract for all subscribers in which the premium is computed on a community rate and in which every subscriber enjoys identical coverage and identical benefits, regardless of income. Hence, payment for an appendectomy under New Jersey Blue Shield—which is considered a fair average amount—is the same whether the subscriber is in a very low income group or whether in an upper income bracket.

In regard to multiple contracts with varying income limits and applicable schedules of payments with varying fees for the same service, reference was made to an approach by Plan representatives to the Department of Banking and Insurance to explore the possibility of their availability under New Jersey Blue Shield Plan. The Department was then, opposed to the use of a double standard of fees in New Jersey which is dependent solely upon the income of the subscriber and not upon the service rendered. The feeling of the Department was that the same fee for a particular service should be available to all subscribers, irrespective of their income. The amount in dollars, provided by the Plan for a particular service, was of no concern to the Department as long as that amount was available to all subscribers. It was agreed by those present, that the attitude of the Department was not unreasonable inasmuch as a Participating Physician is free to charge an additional amount, apart from Plan payment, in cases in which the income is in excess of the contract limits for entitlement for "service benefits."

Leukemia - Lymphoma Study

The State Department of Health has initiated an epidemiologic study of the neoplasms of the lymphatic and haematopoietic tissues in man and animals in the State of New Jersey. This will be done in conjunction with the United States Public Health Service. A U. S.-P.H.S. veterinarian has been assigned to the State Cancer Program for this study.

Your cooperation is sought for this study. This means simply the reporting of any current case of the lymphoma-leukemia group of diseases to your hospital pathologist. The data needed includes a blood smear, or node biopsy plus the name and address of the patient, and of the doctor, with the doctor's permission to interview the patient for the purpose of obtaining an epidemiologic history.

This should not be a burden to any one doctor or pathologist as the calculated morbidity for a year is estimated to be about 1,000 patients for the entire State of New Jersey. The average physician may only see 2 or 3 such patients a year.

Two consultant pathologists, one human and one veterinary, Dr. Bernhard from St. Barnabas Hospital and Dr. McCoy from Rutgers, will be working on this project.

The Trustees and our Cancer Committee urge that all New Jersey physicians give the cooperation necessary to carry out this unusual epidemiologic study.

Obituaries • • •

DR. GEORGE KNAUER

After serving the people of Union County for a half-century, George Knauer died of a heart attack on November 15, 1957. Born in New York City in 1886, he was taken to Elizabeth in infancy and lived here all his life thereafter. In 1908, he was graduated from the medical school at Bellevue, and returned to Elizabeth to practice. He devoted himself increasingly to surgery, and eventually became chief of staff at Alexian Brothers Hospital. At St. Elizabeth's Hospital, he rose through all ranks on the surgical service, retiring as consultant in surgery.

Dr. Knauer was active in civic affairs. He served a term as an Elizabeth city councilman. He was active in several fraternal organizations. He was an F.A.C.S. and at one time was president of the Union County Medical Society.

DR. CALLIE H. LARRABEE

Callie H. Carver, known professionally by her maiden name of Dr. Callie H. Larrabee, died suddenly at the age of 63. Death occurred on October 31, 1957. Born in Maine, Dr. Larrabee received her baccalaureate degree at the University of Maine and her M.D. degree at Cornell University Medical School in 1922. After interning at Cincinnati General Hospital, she came to Summit, N. J. to accept a general practice residency at the Overlook Hospital. She then entered private practice, retaining her association with the Overlook Hospital until the time of her death. She became Associate Attending General Practitioner there in 1953. Dr. Larrabee was active in the affairs of the Union County Medical Society.

DR. FEDERICO LUONGO

One of the state's senior physicians, Dr. Federico Luongo, died at his home on November 4, 1957. Born in Italy in 1875, he was graduated in 1901 from the medical school in Naples. Four years later he came to the United States and became a horse-and-buggy general practitioner. For 43 years he was the City Physician. He was on the staffs of all three hospitals in Orange. Only last year he was the recipient of a golden merit award.

DR. S. HARCOURT PEPPARD

Essex County lost the distinguished director of its Guidance Center on November 16, 1957 with the death that day of Dr. S. Harcourt Peppard. Born in Nova Scotia in 1899, Dr. Peppard was graduated in 1923 from the medical school of Dalhousie University in Canada. He came to the U.S.A. to intern in Massachusetts and a year later became a citizen of our country. In 1926 he entered the New York State Hospital system and in 1930 he won a Child Guidance Fellowship at New York's Institute for Child Guidance. He remained in that field ever since, reaching the position of Associate Director of the Child Guidance Department of New York's Board of Education. In 1948 he accepted appointment in New Jersey to succed the late Dr. J. S. Plant as Director of the famous Essex County Juvenile Clinic.

Under Dr. Peppard's leadership, the clinic changed its name to the Guidance Center, moved to a central-county location in East Orange and expanded from an exclusively diagnostic to a therapeutic resource. Dr. Peppard was a charter founder of the American Academy of Child Psychiatry and was treasurer of the American Orthopsychiatric Association at the time of his death. He belonged to the Essex County Medical Society. A few years ago he was president of the New Jersey Association of Child Guidance Clinics.

DR. J. HARRIS UNDERWOOD

The dean of south Jersey medicine died on November 15, 1957. He was Dr. J. Harris Underwood, founder of the Woodbury hospital which bears his name, one-time health officer, formerly president of the First National Bank of Woodbury and community leader in Gloucester County. Dr. Underwood was graduated from the Jefferson Medical College in 1905. He at one time was president of the Gloucester County Medical Society. Although he always considered himself a family doctor, he was particularly interested in obstetrics, and served for many decades on the obstetrical service of the Cooper Hospital. He was a Fellow of the American College of Surgeons. Dr. Underwood was 81 years of age at the time of his death.

County Society Reports

Bergen

The regular meeting of the *Bergen County Medical Society,* held November 12, 1957, at Bergen Pines was called to order by L. J. Fitzpatrick, M.D., president, at 9:10 p.m. The total attendance before adjournment was 95 members.

The following were elected to membership: To Associate—Michael J. Aria, J. Robert Botta, Jesse D. Greenberg, Herbert E. Keller, Lelio N. Passaglia, William J. Ranucci;

To Regular from Associate—Robert L. Eisenhauer, Gerda Hillyer, Robert E. Kahn, Thomas J. O'Connor, Sherwin H. Raymond;

To Regular by Transfer—R. E. Nelson — from Medical Society of County of Kings; Leave of Absence—Barbara E. O'Connell; To Emeritus—Samuel T. Hubbard.

Dr. Johnson informed the meeting that the contract of sale had been consummated and that lawyers representing the Society and Mr. Davis were preparing the necessary legal steps to void the present deed restriction on one of the two lots. "Turning the wheels of legal progress takes time and matters are progressing satisfactorily," he said.

The Secretary read a letter from Mrs. Carl E. Rothschild, chairman, Program Committee of the Woman's Auxiliary, in which the Auxiliary invited the membership to view its Hobby Show and partake of collation in the downstairs dining room following the meeting.

The Secretary called attention to the Presidential Remarks on page 5 of the November *Bulletin,* in which President Fitzpatrick discussed the far reaching implications of the Medicare Bill, and urged members to attend meetings so that our representatives in Congress may be aware from time to time that broader inclusions in the statute are undesirable but may easily be made.

Resolutions memorializing Drs. Charles H. C. Beakes and Geoffrey C. H. Burns, were read by the Secretary and unanimously adopted.

The Chair introduced Dr. William J. Roe, chairman of the Scientific Program Committee, who presented Dr. Donald B. Louria, Fellow in Research in Infectious Disease at New York Hospital-Cornell Medical Center. Dr. Louria described influenza and its complications in a very interesting and informative manner.

The meeting was adjourned to the downstairs dining room at 11:10 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held November 5, 1957, at the Cherry Hill Inn with Dr. Ralph S. Wright presiding. This meeting was combined with the members of the Woman's Auxiliary as dinner guests of the Society.

Drs. George W. Anderson, Melvin J. Andrews, Charles L. S. Brennan, Jr., Francis E. Barse, David E. Bulluck, Jr., William R. Davison, Theodore J. DeConna, Percival P. Levinson, Ralph A. Skowron and Martin J. Schwartz were welcomed into the Society upon taking the membership oath and signing the register.

Dr. Thomas M. Kain, Sr., was unanimously elected to honorary membership.

Following the dinner, Dr. Ralph S. Wright, President, presented the speaker of the evening, Lt. General William K. Harrison.

EUGENE H. KAIN, M.D.

Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake on Tuesday, December 10, 1957 with Dr. Paul K. Ayars of Port Norris-Millville, presiding. There were 30 members present.

Dr. Henry B. Decker of Camden; a Past-President of The Medical Society of New Jersey; a renowned dermatologist, who has contributed much during his lifetime of dedication to medical science and organized medicine, was unanimously voted to Honorary Membership in the Cumberland County Medical Society.

Further Cumberland County distinguishing honors cited were: Dr. Albert B. Kump is the President of The Medical Society of New Jersey; Dr. Carl Ware, also of Bridgeton, is now the Chairman of the Board of Trustees of The Medical Society of New Jersey; Dr. Sherman Garrison, Jr., of Bridgeton, is Vice-President of the New Jersey Chapter of the American College of Surgeons; Mr. Ralph Vannozzi, administrative director of the Bridgeton Hospital, is the recently elected President of the New Jersey Chapter of the American Hospital Association.

A resolution prepared by Dr. Sherman Garrison, Jr., concerning the use of atomic devices against civilian population was approved by the county

society for reference to the Board of Trustees of The Medical Society of New Jersey.

A fine scientific program, that revolved around the film *Diagnosis and Therapeutic Advances in Liver Disease* was professionally entertaining and instructive. The film was presented by Mr. Lester O. Moore, a representative of the Upjohn Company.

Dinner followed the short business meeting.

LEONARD G. SCOTT, M.D.

Reporter

Essex

The annual meeting of the *Essex County Medical Society* at the Veterans Administration Hospital in East Orange took place on Thursday, November 14, 1957. The speakers, members of the hospital staff, presented interesting and authoritative view points on three subjects of importance to every practicing physician, regardless of his specialty.

Dr. Julius Sobin, Chief of the Psychiatry and Neurology Service, and a member of our own society for more years than he "cares to remember," discussed the psychiatric problems confronting the physician in general practice.

Dr. Lawrence Vaughn, Chief of Thoracic Surgical Department, assisted by Dr. William E. Philip, attending thoracic surgeon, presented a discussion of the surgical treatment of pulmonary tuberculosis. Dr. Gladiel Smith, a Medical Department Staff physician, presented the case of a 404-pound male adult.

WILLIAM A. ANDERSON, M.D.

Reporter

Hudson

With Dr. Harold Gorenberg presiding the first regular monthly meeting of the administrative year was held in Jersey City on October 1, 1957.

Elected to active membership were Dr. Ingeborg Patrylo and Dr. Clifford C. Smith, Jr.

Dr. John J. Bedrick, Chairman of the Dinner-Dance Committee, announced that it is to be held at The Essex House on February 15, 1958.

Dr. Paul Greenberg, chairman of the Diabetes Committee announced that the Diabetes Detection Drive will take place this year the week of November 17 through November 23.

Guest speaker of the evening was Dr. Joseph Michael LoPresti, Associate Professor of Pediatrics, George Washington University School of Medicine. Dr. LoPresti's subject was "Evaluation of the Problem of 'Sore Throat' in Clinical Practice."

Dr. Gorenberg announced the resignation of Miss Agnes Sinott and took the opportunity to introduce Mrs. Julia Z. Wolf as the new Executive Secretary.

With Harold Gorenberg presiding the *Hudson County Medical Society* held its regular meeting at the Jersey City Medical Center on November 5, 1957.

Elected to active membership were: Drs. Alan B. Abrutyn, M. David Ben-Asher, Anna Pittella, Harold Stromeyer, Abraham M. Tornow, Felix Venutolo, William G. Wilkerson, of Jersey City; Francesco Cacace of Weehawken; Keith Kahn of West New York; William D. Melosh of Hackensack; and William E. Wiren of Bayonne.

Guest speaker was Dr. Murray Nussbaum, Instructor in Medicine at the Seton Hall College of Medicine and Dentistry. Dr. Nussbaum spoke on "Evaluation of Patients with a Bleeding Tendency."

Dr. Gorenberg presented the Golden Merit Award to Dr. Samuel Cosgrove. A plaque was also received for Dr. Herman Jaffe and sent to his home.

MATTHEW E. BOYLAN, M.D.

Reporter

Middlesex

A joint dinner meeting of the *Middlesex County Medical Society* and the Middlesex County Pharmaceutical Association was held at the Oak Hills Manor, Metuchen, November 20, 1957. The meeting was called to order by Dr. Gerard R. Gessner, president of the Medical Society.

A brief business session was held at which Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee, presented the following new applicants for membership: The Physicians elected to two-years associate membership were:

Dr. William M. Dawson, Metuchen; Dr. Leonard M. Hirsch, Perth Amboy; Dr. Leon Silverman, New Brunswick.

Elected to regular membership from two-year associate membership were: Dr. Bernard Boodin, Fords; Dr. Francis J. Godrey, Sayreville; Dr. Michael J. O'Kane, New Brunswick; Dr. Vincent J. Pidoto, Metuchen.

Dr. Gessner moved that the Committee on Constitution and By-Laws be empowered to revise both documents and present a copy to each member. This was unanimously approved.

Mr. Harold Kushel opened the Joint Program by introducing several members of the Pharmaceutical Association. A plaque was presented to Mr. Donald Wernik, President of the Middlesex County Pharmaceutical Association, from the National Association of Mental Health. Pamphlets on toxicology were given to each member present.

Mr. Wernik spoke of the close relationship between the physicians and the pharmacists in this county, and expressed the hope this relationship would continue.

The speaker of the evening, Dr. Morton J. Rodman, Professor of Toxicology at Rutgers College

of Pharmacy, spoke on the scope of the poison problem. The talk was well received by all the members present. Miss Marge Cameron presented the entertainment of the evening.

The meeting was then adjourned.

RUDOLPH G. MATFLERD, M.D.

Reporter

Monmouth

Monmouth Memorial Hospital was host to the *Monmouth County Medical Society* at its regular meeting on November 20, 1957. The meeting was conducted by the president, Dr. Theodore Schlossbach.

Dr. Joseph F. Artusio, Head of the Department of Anesthesia, New York Hospital, was the guest speaker. His topic was "Modern Concepts of Inhalation Anesthesia."

Dr. Julio T. Noguera, Asbury Park, was elected to active membership as a transfer from the Puerto Rican Medical Society.

DONALD W. BOWNE, M.D.

Reporter

Ocean

The regular quarterly meeting of the *Ocean County Medical Society* was held October 9, 1957, at the Beacon Hotel in Point Pleasant. The meeting was convened at 6:30 p.m. for dinner, followed by the film, "The Doctor Defendant," a recent release of the AMA Law Department. This film dealt with problems of the physician concerning professional liability and malpractice claims.

The members of the Woman's Auxiliary were present for dinner and the program with their husbands, following which the Ocean County Medical Society and the Auxiliary held separate business meetings. President Dr. Willis B. Mitchell presided and matters of business discussed were concerned with the following:

Establishment of Poison Control Centers in the hospitals of the County, in cooperation with the pharmaceutical and dental societies;

Cooperation with the Ocean County Heart Association as regards promotion of funds and the more effective disbursement of the funds collected by this group;

Cooperation with the Graduate Department of the Seton Hall College of Medicine and the American Cancer Society in regard to Graduate courses proposed to be given in this area;

A meeting with the Ocean County prosecutor in regard to establishment of a Medical Examiner system in this county to replace the present coroner system;

And renewal of contact with the Ocean County Board of Freeholders in regard to appointment of a Sanitary Inspector for the County.

JESSE SCHULMAN, M.D.

Reporter

Salem

Problems of immunization and child care were discussed at the meeting of the *Salem County Medical Society* on Friday, November 15, 1957. The speaker was Dr. Harold Medoff of the Department of Pediatrics of the University of Pennsylvania. He gave the results of world-wide use of the Salk Polio Vaccine up to the present time.

In regard to the vaccine against Asiatic Influenza, Dr. Medoff summarized conflicting reports. He stated that recent studies showed one dose of vaccine to protect about one-half of the persons studied and two injections to protect about four out of five. After discussion of these findings and others, the Society decided that there was no present indication for clinics for mass vaccination. It was agreed that any person desiring influenza vaccination should discuss the problem with his own doctor so that a specific decision of the advisability of vaccination might be made in each case.

W. L. SPROUT, M.D.

Reporter

Union

The November meeting of the *Union County Medical Society* was called to order by its president, Dr. Thomas S. P. Fitch on November 13, 1957, at White Laboratories, Kenilworth.

The guest speaker was Detective Wittcoff of the New Jersey State Police. Mr. Wittcoff spoke on the "Control of Narcotics" and emphasized the need for a proper institution in New Jersey to rehabilitate addicts. He reviewed the salient points of the Harrison Narcotics Act and displayed an exhibit of implements and equipment used by addicts.

At the conclusion of his address, a short business meeting was held. The following were elected to associate membership: Drs. Clare Ann Stein, Howard H. Lehr, Irving H. Smelson and Paul V. Weaver.

A collation was served at the conclusion of the meeting.

ELBERT H. POGUE, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Alcoholism: A Treatment Guide for General Practitioners. By Donald W. Hewitt, M.D. Philadelphia 1957. Lea and Febiger. Pp. 112. ($3.00)

"The physician should confine himself to the role of an interested, heedful listener." "By merely exercising good, everyday, common sense, the physician can often bring the alcoholic's hidden fears, emotional conflicts and guilt complexes out into the open." "The physician must be able to show the alcoholic different ways of solving his problems." "The first step for the general practitioner is very likely to be an effort to uncover the alcoholic's resentful feelings and then to explain them in terms that will help the patient relegate them to the background."

Dr. Hewitt furnishes a hundred pages of such advice. One final sample: "The alcoholic should be counselled to refrain from the use of those things harmful to him."

HENRY A. DAVIDSON, M.D.

Psychiatric Aspects of School Desegregation. Prepared by the Group for the Advancement of Psychiatry, New York 19, N. Y. 1957. Pp. 94. Paper. ($1.00)

The psychiatrists who have prepared this report find that school segregation actually does impair the emotional growth of children. Many who want to keep segregated schools have to fight against their own religious and democratic training to "justify" such a position. The whole issue, the authors point out, is clouded by racial myths, such as delusions that Negroes are intellectually inferior or morally more primitive than white citizens. The emotional background of people who swallow such myths is explored. The book includes a discussion of the anatomy of prejudice, an analysis of the psychodynamics of changing attitudes, a survey of the role of authority in accelerating or blocking such change and an excellent, annotated reading list on the whole subject. This is a carefully documented monograph written with restraint and clarity. It is a good example of how medical (in this case psychiatric) thinking can be applied to contemporary social problems.

HERBERT BOEHM, M.D.

The Story of Peptic Ulcer. By Richard D. Tonkin, M.D. Illustrated by R. K. Hellier. Philadelphia, 1957. Saunders. Pp. 71. ($2.25)

Written for the sophisticated layman, this book tells the story of peptic ulcer through rapid-fire humorous comments and laugh-provoking cartoons. Dr. Tonkin belongs to the sometimes-dangerous "common-sense" school of treatment. "Choice of the diet," he writes, "is really a matter of common sense and requires no special medical knowledge." He is strong on 2-hour feedings and cool to medications. There is a brief explanation of the anatomy and physiology of the ulcer. The book should be previewed by the treating physician first—and if it enunciates nothing that will cause the patient to mutiny—it might well be prescribed for men and women with active ulcers.

—THE MAN WHO OWNS ONE (AN ULCER)

Camden County Medical Society 1846-1956 (History of Camden County Medical Society, the hospitals of Camden County and biographical sketches of the Society members past and present). Camden, N. J., Printed for The Camden County Medical Society by Sinnickson Chew & Sons, Co., 1957, Pp. 151, Illustrated.

This comprehensive and accurate account of medical progress in Camden County, provides a mine of historical information not otherwise available in collected form. Helen F. Schrack, M.D., Historian, the Society's History Committee and the Woman's Auxiliary to the Camden County Medical Society have joined in compiling this commendable book. It is hoped that other county medical societies in New Jersey will publish such volumes at appropriate intervals. These records will be of particular importance in the compilation of a Bicentennial History for The Medical Society of New Jersey in 1966.

In her *Foreword* Dr. Schrack reviews previous historical accounts about the Camden County Medical Society, noting the dearth of material available for the past fifty years. To fill this gap, there follows a review of the Camden body from 1896 to 1956. Past presidents of the Society from 1846 through 1956 are listed, with portraits of eight presidents of The Medical Society of New Jersey

from Camden County. Recipients of the Society's Fifty Year Certificate, twenty-one in number, and membership and activities of The Woman's Auxiliary are also reviewed.

Hospitals in Camden County are described — origins, growth and present services: The Cooper Hospital, the Lakeland Hospitals, Camden County Hospital for Chest Diseases, Municipal Hospital for Contagious Diseases for the City of Camden (and South Jersey Medical Research Foundation Laboratory), The New Jersey State Hospital at Ancora, Our Lady of Lourdes Hospital, and West Jersey Hospital in Camden. Biographies of past and present members of the Society are presented in alphabetical order—valuable outlines for reference. A separate reprint of Dr. Richard M. Cooper's *Historical Sketch of Camden County Medical Society* during its first 25 years (1871), provides a concise account of beginnings — to which Dr. Schrack and her associates have added a fine history of the Society up to the present time.

FRED B. ROGERS, M.D.

Clinical Gastroenterology. Eddy D. Palmer, M.D., Hoeber-Harper, New York, 1957. ($18.50)

Dr. Palmer has compiled for the gastroenterologist a convenient volume which covers every disease, common and rare, of the digestive tract including the liver, extrahepatic biliary tract, pancreas and spleen. All diagnostic methods are well described, as are the gross and microscopic findings.

The anatomic illustrations are Dr. Palmer's own conception, aided by the artist's interpretation. The cardio-esophageal and ileo-cecal areas deserve particular praise. Along with the roentgen photographs are useful diagrams of the pitfalls in diagnostic radiology, which will recall to the older gastroenterologist his own errors, and assist the younger practitioner to avoid them.

The remainder of the text is devoted to the clinical aspects of digestive diseases and presented in clear, ward round conversational style, which is easily absorbed.

With regard to management and treatment, this reviewer takes exception to the author's statement that in dealing with surgery for carcinoma of the stomach ". . . we should give up current measures directed at cure as a bad job now, without waiting for a more effective replacement . . . "

Nor can I agree that diet and drugs should be abandoned in the treatment of uncomplicated duodenal ulcer.

His outline of routine immediate esophagoscopy, gastroscopy, and unlimited radiography during massive bleeding is not, in my opinion, good practice and may be courting disaster.

Despite these objections, the book is a valuable contribution to gastroenterology.

I. GELBER, M.D.

Old Farmer's Almanac for 1958. By Robert B. Thomas. Yankee, Inc. Dublin, N. H. Pp. 124. Paper. ($0.35)

The consciously homespun air of the *Old Farmer's Almanac* begins to wear thin. It is now filled with advertisements for arthritis cures, trusses, diabetes creams, laxatives, health belts, hair dyes, corn removers, fish lures, and smoking-stoppers. Almost lost in the jungle of pulpy advertising is the traditional calendar, weather prophecy, and household hints.

ULYSSES FRANK, M.D.

Dermatologic Formulary. Frances Pascher, M.D., Editor. Hoeber-Harper, N. Y. 16, N. Y. Pp. 172, Second Edition, 1957. ($4.00)

This formulary lists 242 medications (U.S.P., NF., N.N.R. and proprietaries) used in the treatment of skin diseases at the N.Y.U.-Bellevue Medical Center. It has been completely revised in an effort at keeping abreast of the rapid changes in dermatologic therapy. The growth of this *Formulary* in the eighteen years since I worked there is fantastic. Under the able editorship of Dr. Pascher, Drs. Rudold L. Baer, Alfred Pelzig, H. H. Sawicky, and Claire E. Isenstein, Ph.G., have summarized the composite experience in dermatologic drug usage at the busiest out-patient skin clinic on earth. Such a volume is of great value to anyone treating dermatologic diseases.

Many skin diseases are listed in the index, so that the book may be used both as a formulary and a therapeutic guide. Since many dermatologic drugs can be harmful if improperly used, (e.g. arsenic, steroid hormones) contra-indications are precisely detailed.

The only deficiency, and it is a general one in this age of factory-prepared medications, lies in the obvious impossibility of listing competitive proprietary formulae. Since this book is exactly what it sets out to be, a list of medications used at one hospital, this does not imply criticism. On the contrary, it is a gallant effort to keep alive the fine art of prescription writing.

Thirteen pages are used to list emergency kits, instructions for use of corticosteroids, and routine directions to the patient in treatment of various dermatoses.

It is clear to this former student of Dr. Pascher's that she is still the gifted teacher and physician that I remember.

JACOB BLEIBERG, M.D.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI January, 1958 No. 1

Report of the Advisory Committee on BCG to the Surgeon General of the Public Health Service

Issued by U. S. Department of Health, Education, and Welfare, Public Health Service, October 21, 1957.

A committee invited by Surgeon General Leroy E. Burney, to examine the Public Health Service policy and program in the field of BCG vaccination, met in Washington. June 14, 1957. The committee was asked to formulate a new statement and make new recommendations, if it seemed appropriate, on the use of BCG vaccination as a public health procedure, and on further research as to its value.

A previous advisory committee had considered the question of BCG vaccination, and a statement on the use of BCG, consistent with its recommendations was issued by the Public Health Service in August, 1950. The Public Health Service then stated that mass BCG vaccination programs were not indicated in this country, and that vaccination should be limited to persons with unusually great exposure to tuberculous infection.

It appeared to the present committee that a logical evaluation of BCG vaccination and the formulation of recommendations on the policy of the U. S. Public Health Service, could be made only after broad consideration of the present status of the tuberculosis problem; facts on BCG vaccination that have become available since the last statement; the contribution to be expected from BCG in diminishing the problem; and the advantages and disadvantages of various public health applications of BCG.

Present Status of Tuberculosis Problem. Nearly all aspects of the tuberculosis problem have undergone great changes during the past decade. The mortality rate has decreased from about 30 per 100,000 in 1946, to less than 10 in 1956. The morbidity rate and the risk of infection have also declined, but not so rapidly. The consequences of tuberculosis morbidity have been lessened by antimicrobial agents, particularly isoniazid. Further research on the effectiveness of antimicrobial drugs in first infection is desirable.

BCG Vaccination. The basic premise for use of BCG is that the changes produced in the host by vaccination will protect in some measure against the hazards resulting from tuberculous infection. It is generally accepted that vaccination be restricted to noninfected persons, *i.e.*, nonreactors to tuberculin. In general population groups, it has been usual to limit vaccination to the younger segments, in which there has been little opportunity for infection.

Recent well-controlled studies have shown that tuberculous disease is more likely to develop among those found positive to tuberculin than among those not reacting. Accordingly, chief attention from the point of view of tuberculosis control, should be devoted to those found to react to tuberculin. It is obvious, however, that every tuberculosis program should include measures to prevent infection.

The value of BCG vaccination in controlling tuberculosis in the U. S. has been a matter of controversy in recent years. There is convincing evidence that vaccination in man with a strain of BCG known to be of high potency leads to some degree of increased resistance against tuberculous disease. How long this increased resistance persists is not known. BCG appears to be as safe as other vaccines in common use, but cases of progressive disease and death attributable to BCG have been reported.

In considering disadvantages attendant upon use of BCG vaccination, the tuberculin reaction was stressed. Since BCG vaccination converts nonreactors into reactors to tuberculin, the procedure makes it impossible to use the tuberculin test: (1) as evidence of recent infection in the individual;

(2) as an index of infection in population groups; (3) for the location of sources of contagion; (4) as a preliminary screening device or, (5) for differential diagnosis. This is of increasing importance in the light of the current continuing decline in the prevalence of infection and manifests increasing concern over the hazards of excessive radiation by x-rays.

Wide use of BCG vaccination may lead to a false sense of security, which could result in failure to observe precautions that otherwise might be taken.

Since 1946 numerous investigations have shown a wide range of variation from 0 to 80 per cent in the reported efficacy of BCG. The degree of protection afforded by the vaccine appears to be far from absolute. In a British Medical Research Council study, the morbidity rate among the vaccinated was only one-fifth of that reported for a nonvaccinated group of 13,200 studied concurrently: in a Public Health Service study in Puerto Rico, the rate was two-thirds of that recorded for some 27,000 controls concurrently studied.

In a Public Health Service trial of BCG vaccination in Georgia and Alabama there was no statistically significant difference in the tuberculosis developing among vaccinated and nonvaccinated persons after six years of observation. A striking finding in both the British and PHS studies was a high subsequent incidence of tuberculosis morbidity in persons strongly sensitive to tuberculin at the time of surveys.

The members of the committee were particularly impressed by the apparent variability in vaccinating potency of different BCG strains, as shown by laboratory studies and by the diversity of results in field trials. The significance of apparent variations in potency of strains is not yet understood.

Reductions in tuberculosis mortality have been as great in certain European countries that do not practice BCG vaccination as in those of comparable size and economic state in which BCG is widely used.

With all of these considerations in mind the committee did not believe that a categorical statement on the degree of protection afforded by BCG vaccination could be made.

The committee expressed the opinion that the use of BCG should be determined by local circumstances such as the strength of the tuberculosis program, the prevalence of tuberculosis in the community at the time, and the probable risk of infection in the future. The question will arise chiefly where exposure is high and weakness in other means of control is recognized.

The committee is convinced that large-scale BCG vaccination programs, including routine vaccination of the newborn, are not indicated in this country. However, advantages of vaccination outweigh the disadvantages for tuberculin-negative persons who are exposed to a definite risk of infection. Under certain circumstances, the following individuals and groups are examples of suitable subjects for BCG vaccination:

1. Physicians, nurses, medical and nursing students, laboratory workers, and hospital employees. (If a hospital has established an adequate tuberculosis control program very little exposure to tuberculosis will occur in that institution.) 2. Persons unavoidably exposed to continued contact with infectious cases of tuberculosis in the home. 3. Patients, inmates and employees of institutions such as mental hospitals and prisons, in which case-finding programs indicate that exposure to tuberculosis is likely to be high.

It is the consensus of the committee that, in view of the apparent low risk of tuberculosis among present nonreactors in the United States, new investigations on the value of BCG cannot be made without excessively large study populations. For this reason, it did not recommend that the Public Health Service initiate new vaccination trails. However, it recommends strongly that the controlled studies on population groups already started be carried on as long as they furnish significant information on the rates of development of tuberculosis in the vaccinated and control groups now under observation.

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Dr. Horace L. Hodes
Dr. Esmond R. Long, *Chairman*
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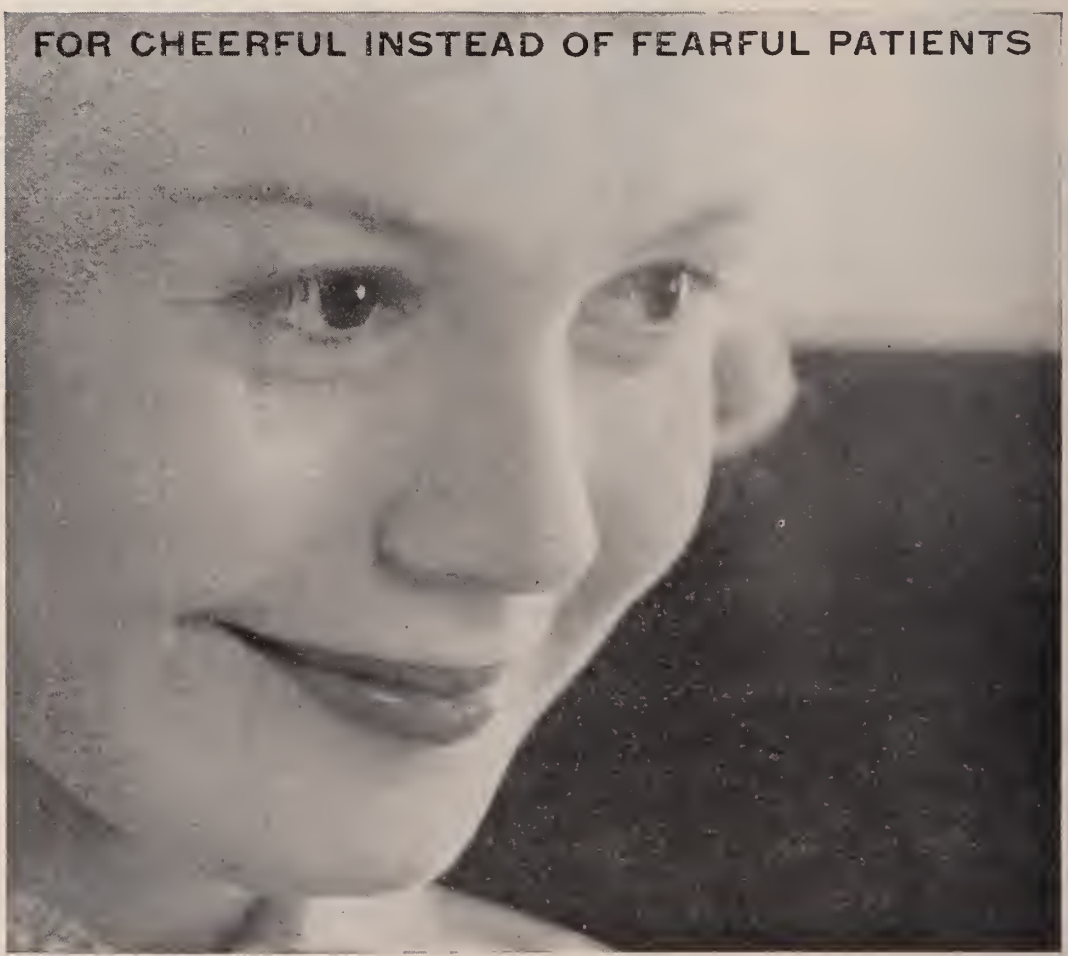
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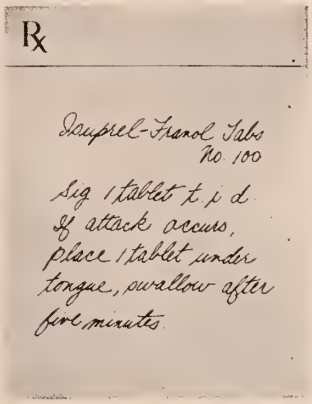
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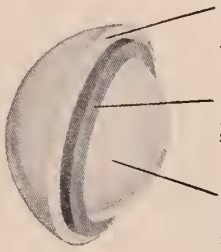
1. Fromer, J. L., and DeRisio, V. J.: *Lahey Clin. Bull.* 10:45, Oct.-Dec., 1956.

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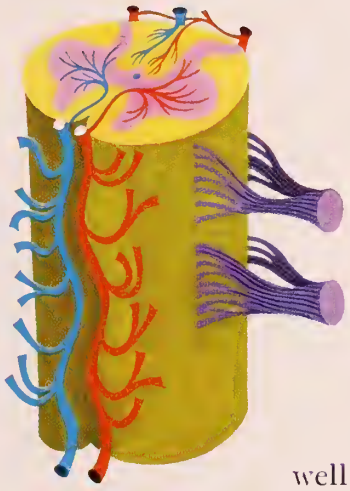
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*Belafsky, H. A., Breslow, S. and Shangold, J. E.: Meprobamate in pregnancy. Obst. & Gynec. 9:703, June 1957.

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*Silbert, N. E., Ciba Clinical Symposia; 6: 86; May 1954
Mechaneck, I., Annals of Allergy; 12: 164: March 1954
Rosen, F. L., J. Med. Soc. N. J.; 51: 110: March 1954
Mueller, H. L., & Hill, L. W.: N. E. J. of Med; 249: 726, 1953

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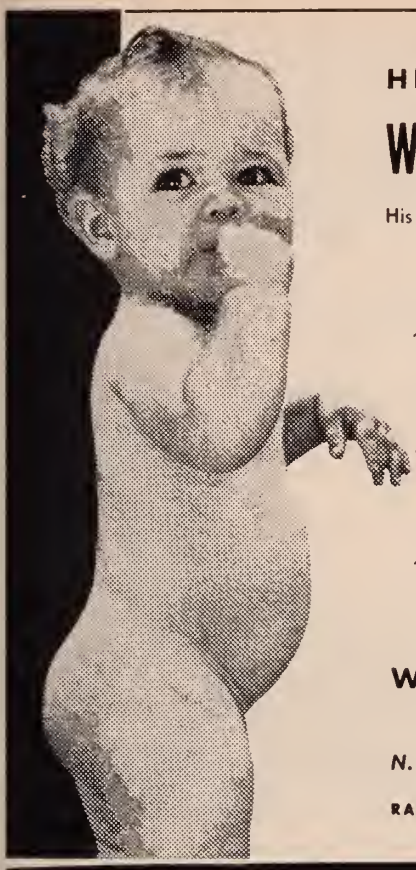
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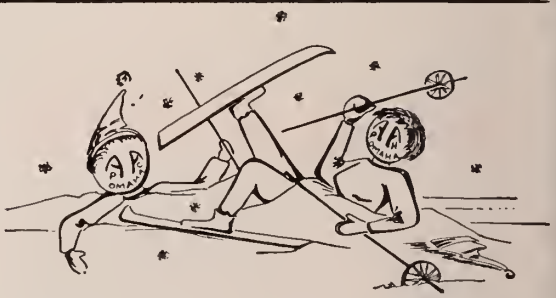
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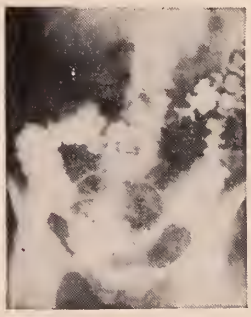
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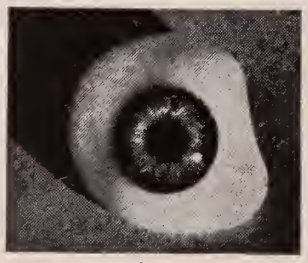
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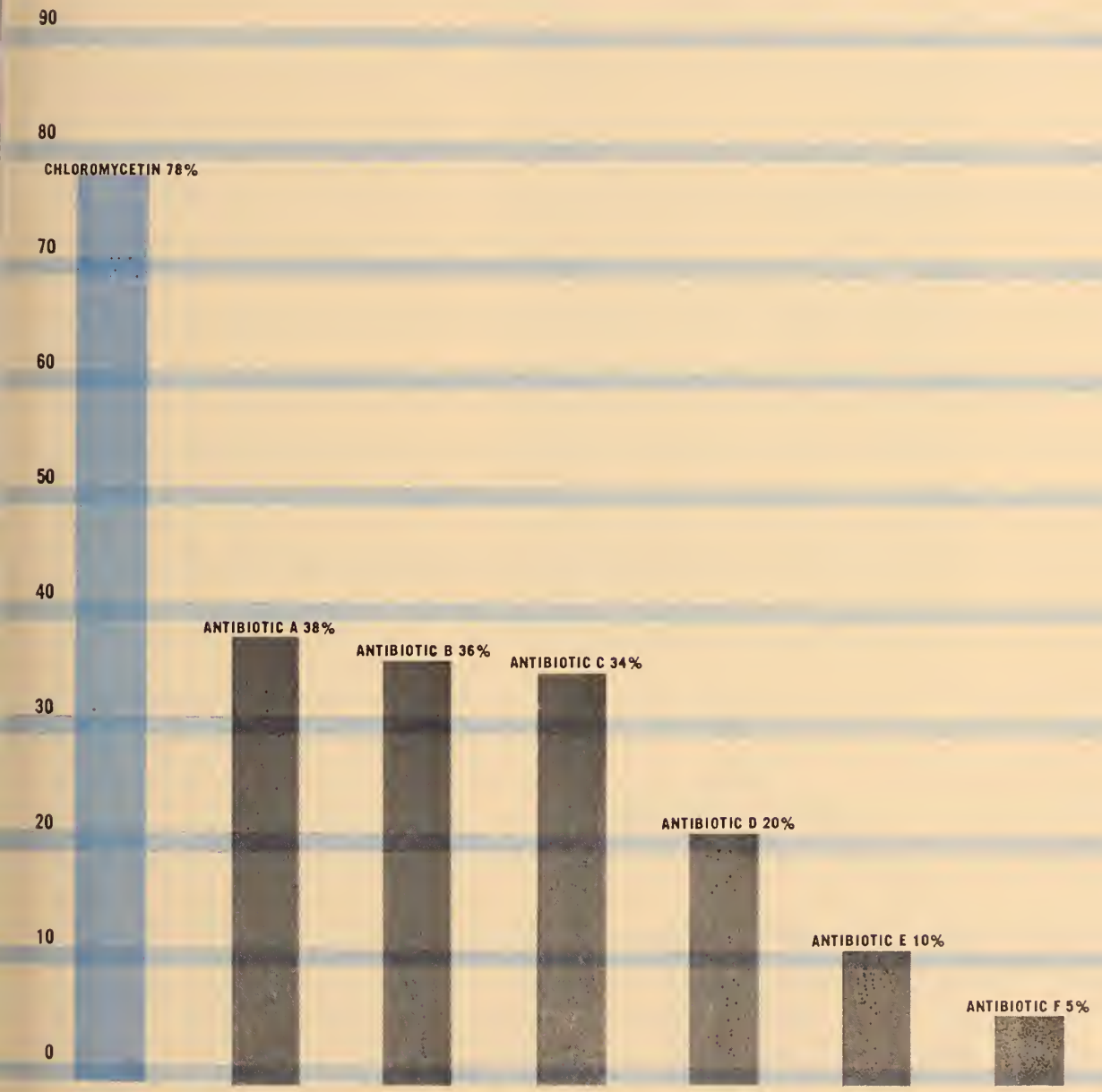
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Breast feeding is the procedure of choice for the newborn. But it may need to be complemented with standard formulas given here.

The first feeding, 12 hours after birth, consists of a prelacteal solution of 5% Karo Syrup, one or two ounces, repeated at two-hour intervals. Breast feeding is started on the second day for five-minute intervals and the prelacteal feeding continued immediately thereafter and between nursings.

Formula feeding is given on the second day if breast feeding is denied. The small infant prefers the three-hour schedule and the large infant the four-hour schedule.

The initial formula is a low-caloric milk mixture, gradually increased in concentration over several day intervals according to tolerance. Standard formulas for whole cow's milk or evaporated milk modified with diluted Karo Syrup as shown here, constitute the dietary regimen for well newborns.

First formulas for newborns, concentrated according to tolerance

Evaporated Milk Formulas: 3 oz. q 4h x 6 feedings

	FORMULA I 12.5 cals./oz.	FORMULA II 16 cals./oz.	FORMULA III 20 cals./oz.
Evap. Milk . .	4 oz.	5 oz.	6 oz.
Water	14 oz.	13 oz.	12 oz.
Karo Syrup . .	1/2 oz.	3/4 oz.	1 oz.

Whole Cow's Milk Formulas: 3 1/2 oz. q 4h x 6 feedings

	FORMULA I 11 cals./oz.	FORMULA II 11.5 cals./oz.	FORMULA III 13.5 cals./oz.
Whole Milk . .	8 oz.	9 oz.	10 oz.
Water	12 oz.	11 oz.	10 oz.
Karo Syrup . .	1/2 oz.	3/4 oz.	1 oz.

ADVANTAGES OF KARO IN INFANT FEEDING



Composition: Karo is a superior maltose-dextrin mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo costs 1/5th as much as expensive milk modifiers and is available at all food stores.

Medical Division
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N.Y.

ACHROCIDIN*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula capable of modifying the course of common upper respiratory infections . . . particularly valuable during respiratory epidemics; when bacterial complications are likely; when patient's history is positive for recurrent otitis, pulmonary, nephritic, or rheumatic involvement.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

Available on prescription only.

TABLETS *(sugar coated) Each Tablet contains:*

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored) Each teaspoonful (5 cc.) contains:*

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK
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Lederle

AN AMES® CLINIQUICK

CLINICAL BRIEFS FOR MODERN PRACTICE



just wet... ...and read

does proteinuria occur more frequently in any type of heart failure—myocardial hypertrophy, mitral valve, coronary artery, aortic valve or hypertensive heart disease?

No. The incidence of proteinuria is about equal among the various types of cardiac patients in failure.

Source—Race, G. A.; Scheifley, C. H., and Edwards, J. E.: Circulation *13*:329, 1956.

first colorimetric test for proteinuria

ALBUSTIX® TRADEMARK Reagent Strips. Bottles of 120.

also available as:

ALBUTEST® BRAND Reagent Tablets. Bottles of 100 and 500.

AMES COMPANY, INC • ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto 45558

when are tranquilizers indicated in pediatrics ?

Some doctors have questioned the use of tranquilizers in children. They feel, and rightly so, that these drugs should not be used as palliatives to mask distressing symptoms, while etiological factors go uncorrected. But there are three situations in which even the most conservative physician would not hesitate to use tranquilizers:

1. When the usually well-adjusted child needs a buffer against temporary emotional stress, such as hospitalization.
2. When a child needs relief from an anxiety-reaction that is in turn anxiety-provoking, so as to pave the way for basic therapy.
3. When anxiety underlies or complicates somatic disease, as in asthma.

In such situations, tranquilizers are likely to be more effective and better tolerated than previously accepted therapy, such as barbiturates.

But the question arises: which tranquilizer is suitable for children?

Most of the physicians now using tranquilizers in pediatric practice have found the answer to be ATARAX, confirming the conclusions of repeated clinical studies.

ATARAX is effective in a wide range of pediatric indications.
ATARAX has produced a "striking response" in a wide range of hyperemotive states.* In a study of 126 children, "the calming effect of hydroxyzine (ATARAX) was remarkable" in 90%.* Among the conditions that are improved with ATARAX are tics, nervous vomiting, stuttering, temper tantrums, disciplinary problems, crying spasms, nightmares, incontinence, hyperkinesia, etc.*

ATARAX is well tolerated even by children.
"ATARAX appears to be the safest of the mild tranquilizers. Troublesome side effects have not been reported. . . ."*

ATARAX offers two pediatric dosage forms.
ATARAX Syrup is especially designed for acceptability by medicine-shy youngsters. A small 10 mg. tablet is also available. In either case, you will get a rapid, uncomplicated response. Why not, for the next four weeks, prescribe ATARAX for your hyperemotive pediatric patients. See whether you, too, don't find it eminently suitable.

*Documentation on request

PEACE OF MIND ATARAX®
(BRAND OF HYDROXYZINE)

ATARAX
in any hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

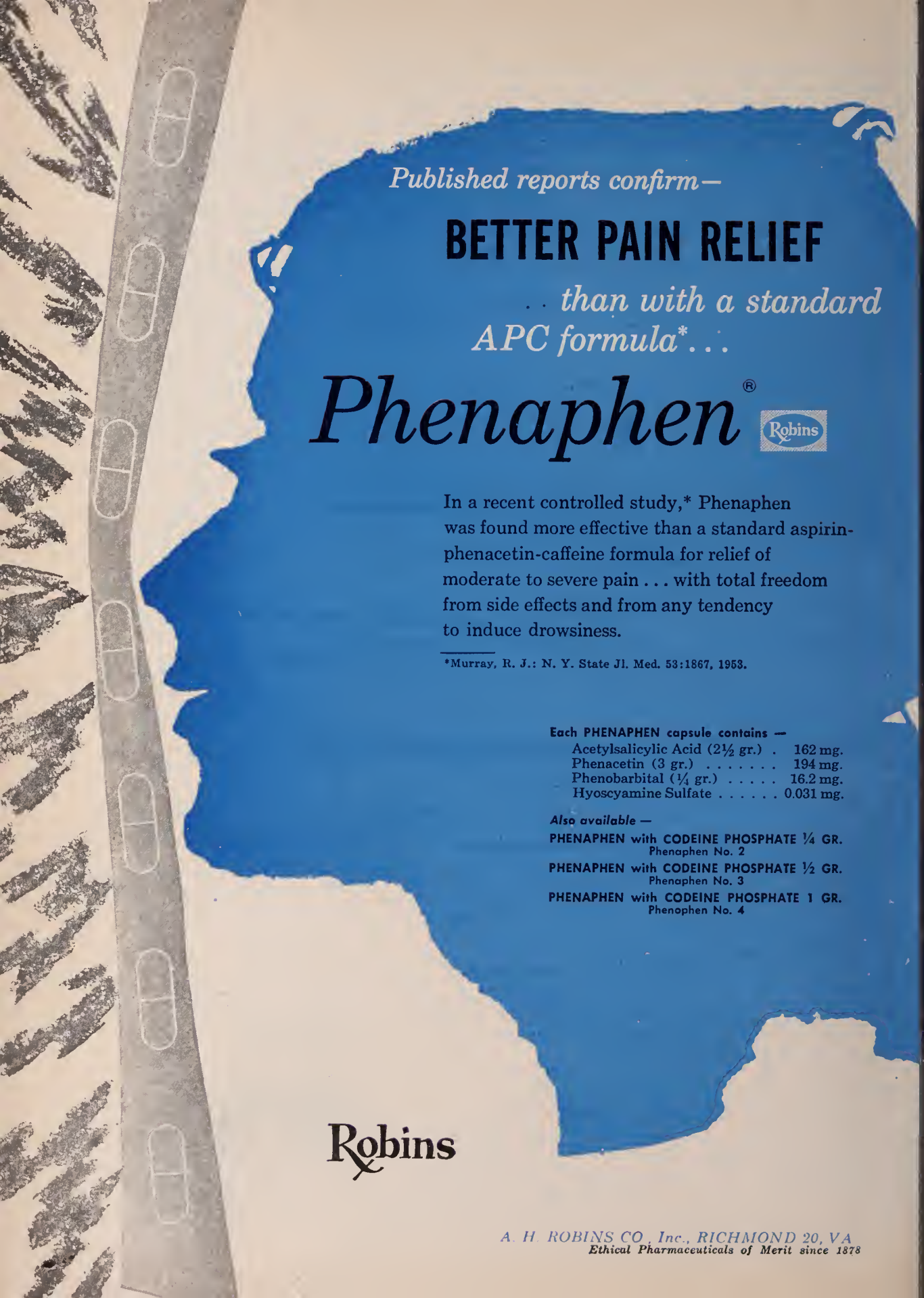
for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

M. A. Seidel M.D.
Medical Director

Roerig
New York 17, New York
Division, Chas. Pfizer & Co., Inc.



Published reports confirm—

BETTER PAIN RELIEF

. . than with a standard APC formula. . .*

Phenaphen®

Robins

In a recent controlled study,* Phenaphen was found more effective than a standard aspirin-phenacetin-caffeine formula for relief of moderate to severe pain . . . with total freedom from side effects and from any tendency to induce drowsiness.

*Murray, R. J.: N. Y. State Jl. Med. 53:1867, 1953.

Each PHENAPHEN capsule contains —

Acetylsalicylic Acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine Sulfate	0.031 mg.

Also available —

PHENAPHEN with CODEINE PHOSPHATE ¼ GR.
Phenaphen No. 2

PHENAPHEN with CODEINE PHOSPHATE ½ GR.
Phenaphen No. 3

PHENAPHEN with CODEINE PHOSPHATE 1 GR.
Phenophen No. 4

Robins

A. H. ROBINS CO., Inc., RICHMOND 20, VA
Ethical Pharmaceuticals of Merit since 1878

NOW—FROM ABBOTT LABORATORIES



AN ANTIBIOTIC TRIAD
—FOR THE CONTROL OF
ALL COCCAL INFECTIONS

FILMTAB®

Erythrocin®

STEARATE (Erythromycin Stearate, Abbott)

against staph-, strep- and pneumococci



Indications

ERYTHROCIN is indicated in treating infections caused by staphylococci, streptococci (including enterococci), and pneumococci. Indicated also, in treating infections that have become resistant to other antibiotics. May be used for patients who are allergic to penicillin or other antibacterials.

Dosage

Usually administered in a total daily dose of 1 to 2 Gm., depending on severity of infection. Suggested dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours.

Supplied

In bottles of 25 and 100 *Filmtabs* (100 and 250 mg.). Also, in tasty, cinnamon-flavored oral suspension, in 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.



REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension. Abbott

802069

Compocillin-V®

for those penicillin-sensitive organisms



802071

Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

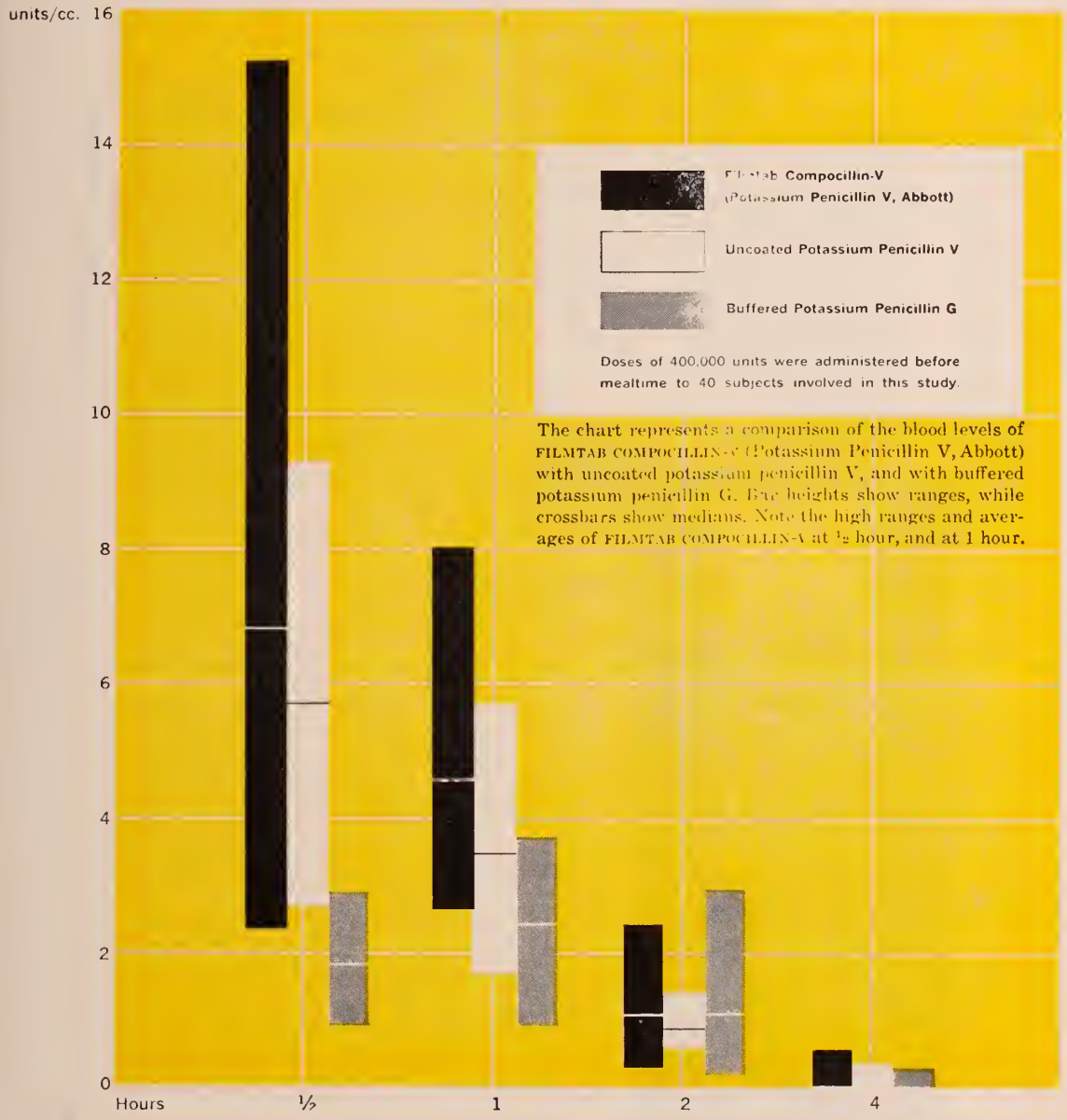
Dosage

Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed — stays stable for at least 18 months.

Abbott

Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient



802070

Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED



SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

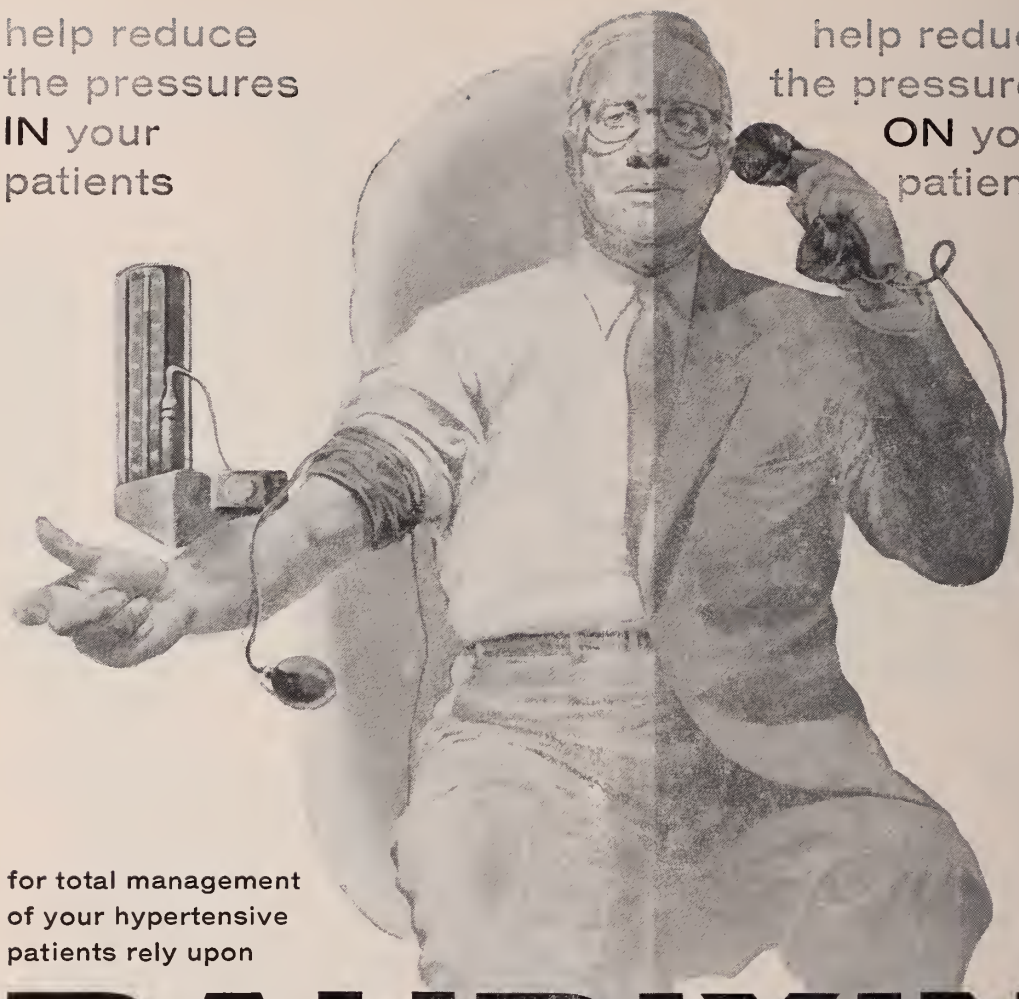
1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

Abbott

help reduce
the pressures
IN your
patients

help reduce
the pressures
ON your
patients



for total management
of your hypertensive
patients rely upon

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

Raudixin provides gradual, sustained lowering of blood pressure in hypertensive patients, as well as a mild bradycardia. Hence, the work load of the heart is reduced.

"... often preferred to reserpine in private practice because of the additional activity of the whole root."

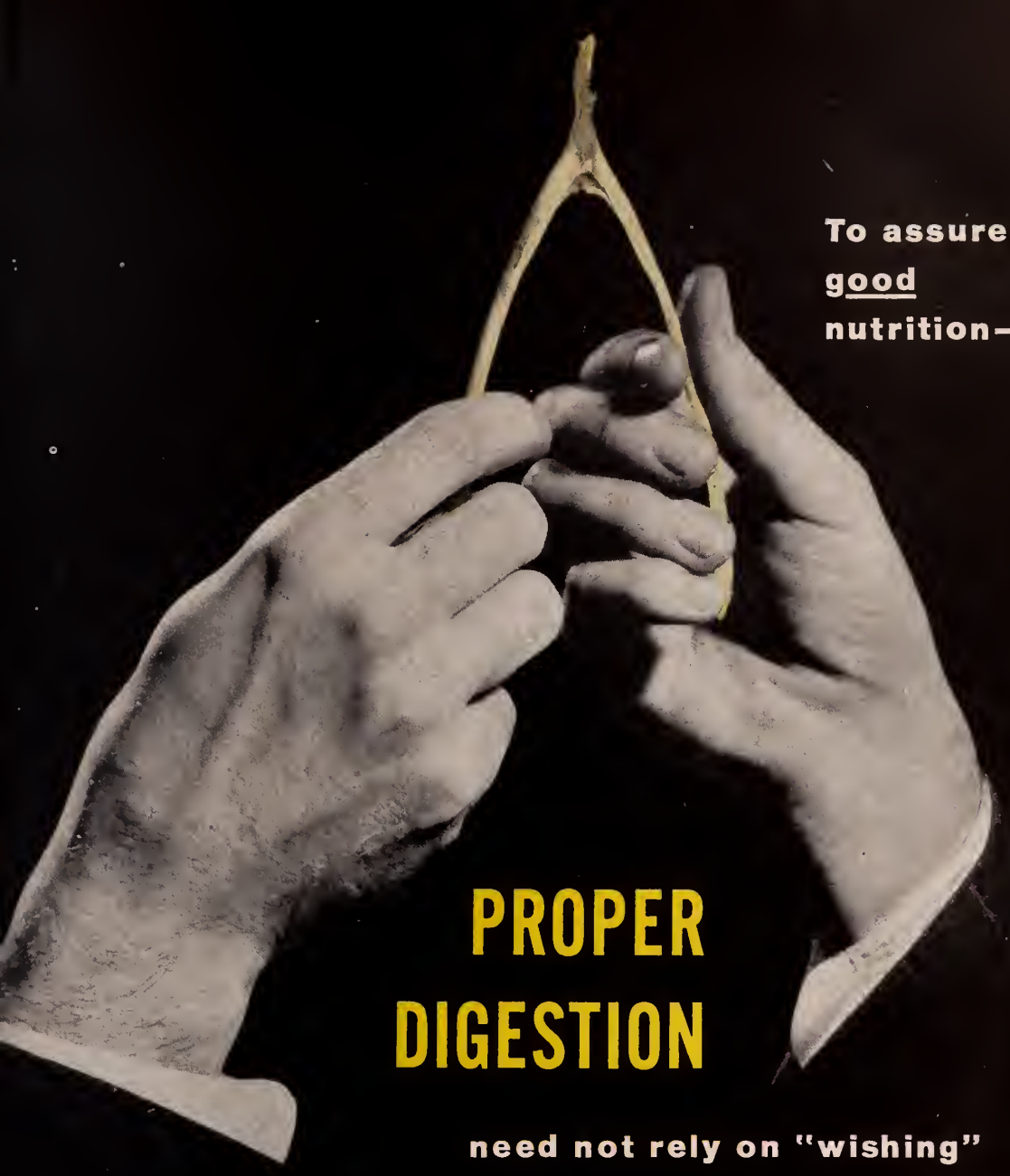
Corrin, K. M.: Am. Pract. & Dig. Treatment 8:721 (May) 1957.

Tranquilizing Raudixin helps relax the anxious hypertensive patient so that he is better able to cope with external pressures without being overwhelmed by them. By reducing these anxieties and tensions, Raudixin helps break the mental tension –hypertension cycle.

Dosage: Two 100 mg. tablets once daily; may be adjusted within range of 50 to 300 mg. *Supply:* 50 and 100 mg. tablets. Bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

"RAUDIXIN" IS A SQUIBB TRADEMARK



To assure good nutrition—

PROPER DIGESTION

need not rely on "wishing"

Each double-layered Entozyme tablet contains:

Pepsin, N.F. ..... 250 mg.
—released in the stomach from gastric-soluble outer coating of tablet.

Pancreatin, U.S.P. ..... 300 mg.

Bile Salts ..... 150 mg.
—released in the small intestine from enteric-coated inner core.

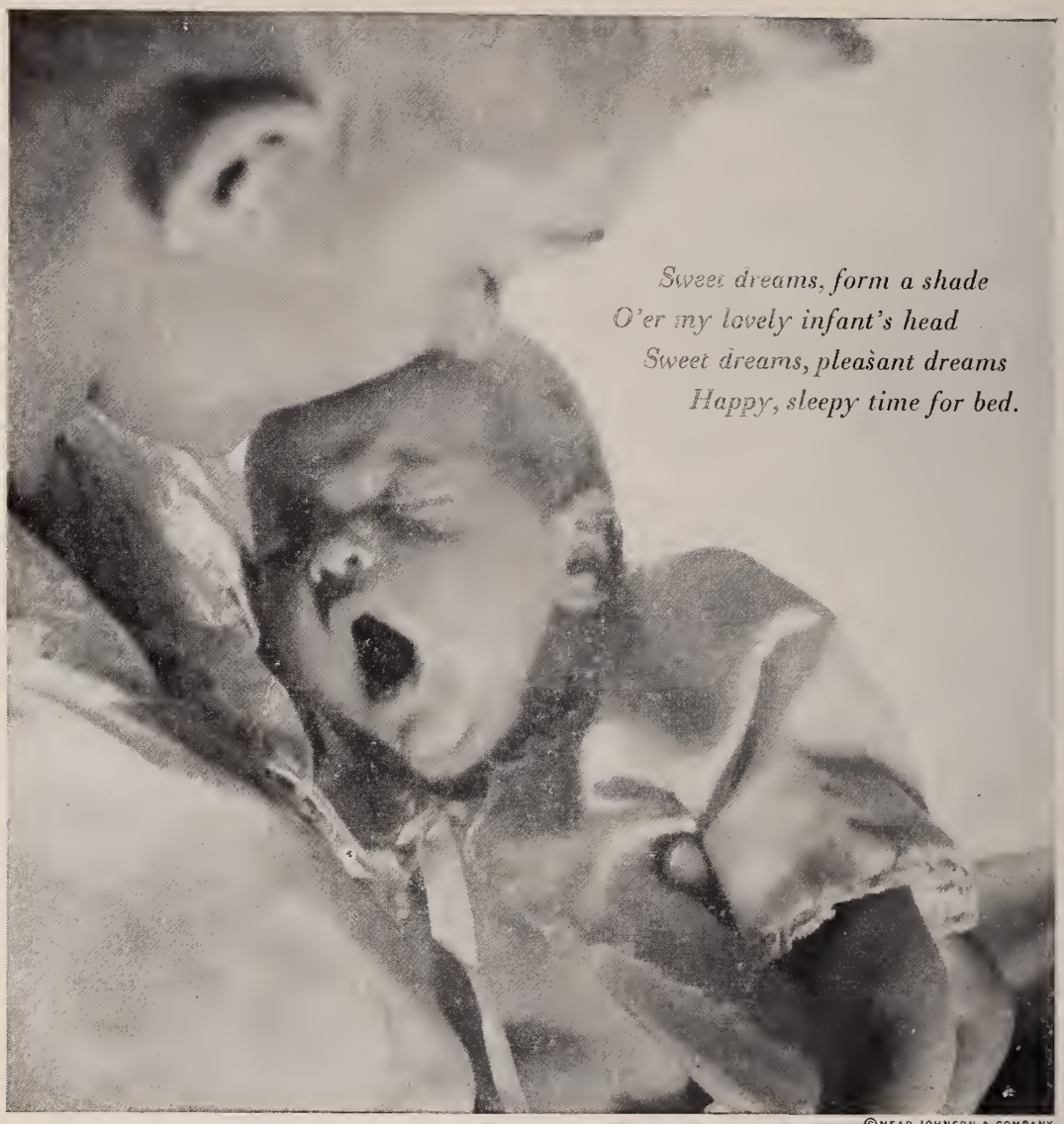
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Ethical Pharmaceuticals of Merit since 1878

As a comprehensive supplement to deficient natural secretion of digestive enzymes, particularly in older patients, ENTOZYME effectively improves nutrition by bridging the gap between adequate ingestion and proper digestion. Among patients of all ages, it has proved helpful in chronic cholecystitis, post-cholecystectomy syndrome, subtotal gastrectomy, pancreatitis, dyspepsia, food intolerance, flatulence, nausea and chronic nutritional disturbances.

For comprehensive digestive enzyme replacement—

ENTOZYME®

Robins

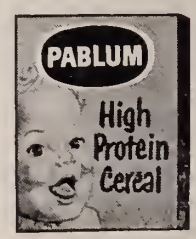


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You can specify PABLUM BRAND® *with confidence*

Pablum High Protein Cereal was created to help meet baby's protein needs during the first year of growth. It is 35% protein, a level much higher than in many foods known for high protein content. It satisfies baby's hunger for longer periods of time—longer *night* periods. Babies also relish Pablum Mixed Cereal, Rice Cereal, Barley Cereal and Oatmeal . . .

the baby cereals made to pharmaceutical standards of quality—especially processed for extra smoothness and lasting freshness.

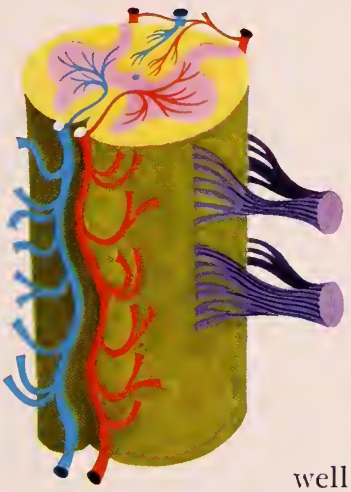


Pablum Products DIVISION OF MEAD JOHNSON & CO., EVANSVILLE, INDIANA • MANUFACTURERS OF NUTRITIONAL AND PHARMACEUTICAL PRODUCTS.

relaxes both mind & muscle

without impairing mental or physical efficiency





well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets. *Usual dosage:* One or two 400 mg. tablets t.i.d.

For anxiety, tension and muscle spasm in everyday practice.

Miltown®

tranquilizer with muscle-relaxant action

2-methyl-2-n-propyl-1,3-propanediol dicarbamate



THE ORIGINAL MEPROBAMATE

DISCOVERED & INTRODUCED BY

WALLACE LABORATORIES

NEW BRUNSWICK, NEW JERSEY

CM-6058

AN IMPORTANT ADVANCE IN MENOPAUSAL THERAP

Because it replaces *half* control with *full* control.

Because it treats the *whole* menopausal syndrome

Because *one* prescription manages *both* the psychic and somatic symptoms.

Two-dimensional treatment of the menopause

SUPPLIED: Bottles of 60 tablets.
Each tablet contains:

MILTOWN® (meprobamate, Wallace) ..... **400 mg.**
2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate.
U. S. Patent No. 2,724,720.

Conjugated Estrogens (equine) ..... **0.4 mg.**
Licensed under U. S. Patent No. 2,429,398.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

Samples and literature on request.

"Milprem"

MILTOWN®
A Proven Tranquilizer
+
CONJUGATED ESTROGENS (EQUINE)
A Proven Estrogen

WALLACE LABORATORIES, *New Brunswick, N. J.*
who discovered and introduced Miltown, the original meprobamate.



Presenting an advance in the treatment of

VAGINITIS:

a new specific moniliacide MICOFUR T.M. brand of nifuroxime

now added to

the established specific trichomonacide FUROXONE® brand of furazolidone

IMPROVED

TRICOFURON®

VAGINAL SUPPOSITORIES AND POWDER

85% CLINICAL CURES*

In 219 patients with either trichomonal vaginitis, monilial vaginitis or both, clinical cures were secured in 187.

71% CULTURAL CURES*

157 patients showed negative culture tests at 3 months follow-up examinations. Patients reported rapid relief of burning and itching, often within 24 hours.



STEP 1 *Office* administration of TRICOFURON VAGINAL POWDER IMPROVED at least once weekly.



STEP 2 *Home* use of TRICOFURON VAGINAL SUPPOSITORIES IMPROVED by the patient, 1 or 2 daily, including the important menstrual days.

*Combined results of 12 independent clinical investigators. Data available on request.

SUPPOSITORIES:
0.375% Micofur, 0.25% Furoxone.

POWDER:
0.5% Micofur, 0.1% Furoxone.

EATON LABORATORIES, NORWICH, NEW YORK

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

BONADOXIN®

STOPS MORNING SICKNESS...BUT





...IT DOESN'T STOP THE PATIENT

BONADOXIN brings relief to 88.1% of patients...often within a few hours.[1,2] But it does not produce drowsiness, or side effects associated with over-potent antinauseants. With safe BONADOXIN, "toxicity and intolerance...[is] zero."[2]

Is she blue at breakfast? Prescribe BONADOXIN. Usually just one tablet at bedtime stops nausea and vomiting of pregnancy...

and just one supplies the full 50 mg. of pyridoxine. ⇐

EACH TABLET CONTAINS:
MECLIZINE HCl . . . . . 25 mg.
PYRIDOXINE HCl . . . . . 50 mg.

Bottles of 25 and 100.

References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

...and for a nutritional buildup plus freedom from leg cramps*

STORCAVITE®

phosphate-free calcium, 10 essential vitamins, 8 important minerals. Bottles of 100.

*due to calcium-phosphorus imbalance

ROERIG Rx

NEW YORK 17, NEW YORK
Division, Chas. Pfizer & Co., Inc.

Stepped-up performance...



New rapid-acting ACHROMYCIN V Capsules offer more patients consistently high blood levels—at no sacrifice to the broad anti-infective spectrum of ACHROMYCIN Tetracycline, its low incidence of side effects, or its dosage and indications.

The pure, unaltered crystalline tetracycline HCl molecule of ACHROMYCIN, now buffered with citric acid, provide



MYCIN V

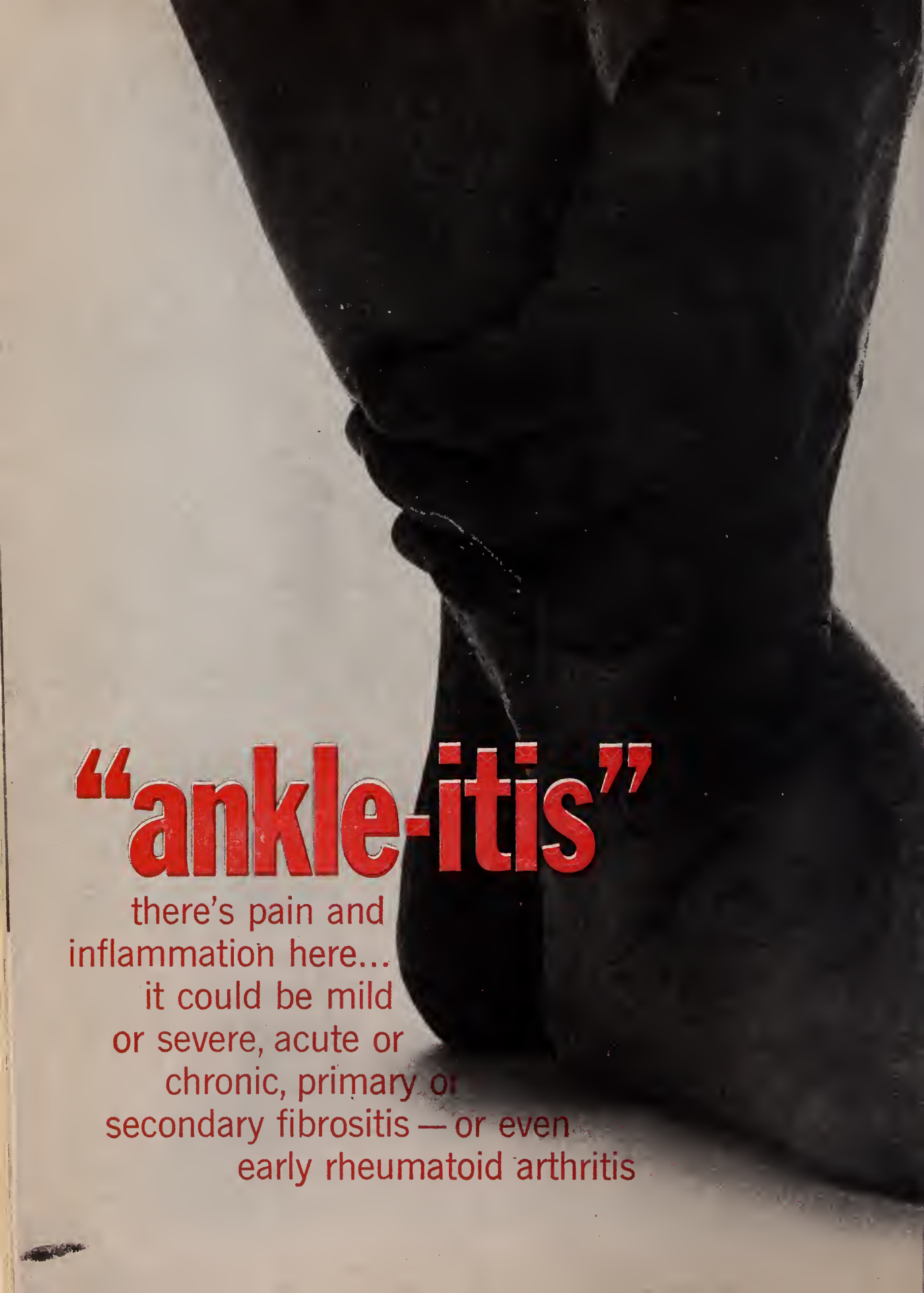
Tetracycline HCl Buffered with Citric Acid

prompt and high blood levels, faster broad-spectrum action ...rapidly decisive control of infections. New ACHROMYCIN V Capsules do not contain sodium.

REMEMBER THE V WHEN SPECIFYING ACHROMYCIN V

CAPSULES: (blue-yellow) 250 mg. tetracycline HCl (buffered with citric acid, 250 mg.); 100 mg. tetracycline HCl (buffered with citric acid, 100 mg.). **ACHROMYCIN V DOSAGE:** Recommended basic oral dosage is 6-7 mg. per lb. body weight per day. In acute, severe infections often encountered in infants and children, the dose should be 12 mg. per lb. body weight per day. Dosage in the average adult should be 1 Gm. divided into four 250 mg. doses.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK Lederle


"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1. 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SG-J-518

PROFESSIONAL LIABILITY PROTECTION

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Kindly send information on limits and costs of Society's Professional Policy

Name .....

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in common mixed infections
...tetracycline phosphate alone

PANMYCIN* Phosphate

for children:

PANMYCIN KM Syrup

BROAD-SPECTRUM TETRACYCLINE IN ITS MOST EFFICIENT FORM

Produces more tetracycline in the blood with no more in the dose. No calcium to depress blood levels.[1] Basic broad spectrum therapy in bronchitis, pharyngitis, otitis media, tonsillitis and other common respiratory infections.

1. Welch, H., Wright, W. W. and Stafford, A. W.: Antibiotic Med. & Clin. Therapy 4:20, 1957

in potentially serious infections
...tetracycline phosphate plus novobiocin

PANALBA*

for children:

PANALBA KM Granules

THE BREADTH OF PANMYCIN PHOSPHATE PLUS THE ANTIMICROCOCCAL DEPTH OF ALBAMYCIN[1]

Offers maximum antimicrobial action at the earliest possible moment. The antibiotic preparation of first resort in pneumonia of unknown etiology, carbuncles multiple furunculosis, cellulitis, and infections resistant to previous therapy

for the 7 monilia-susceptible types
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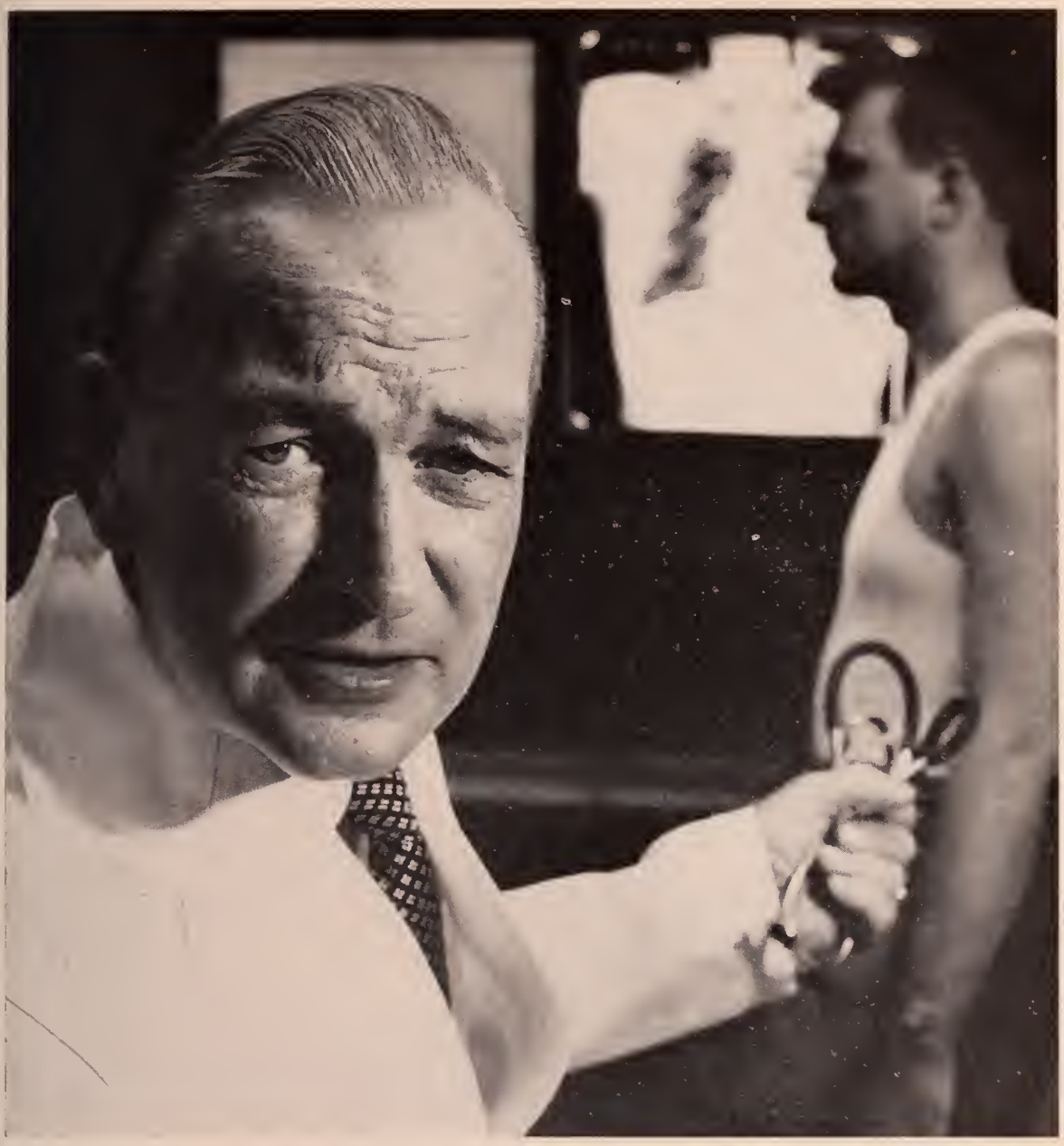
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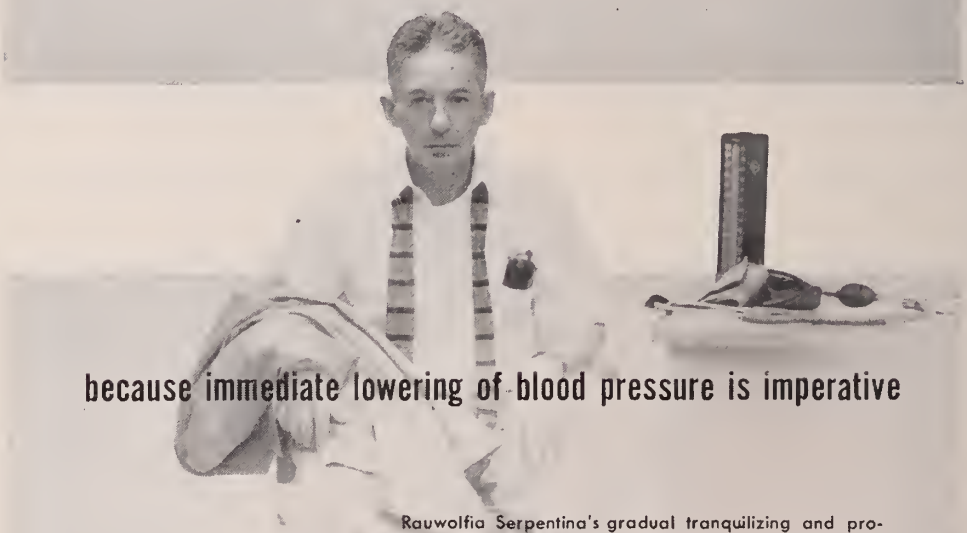
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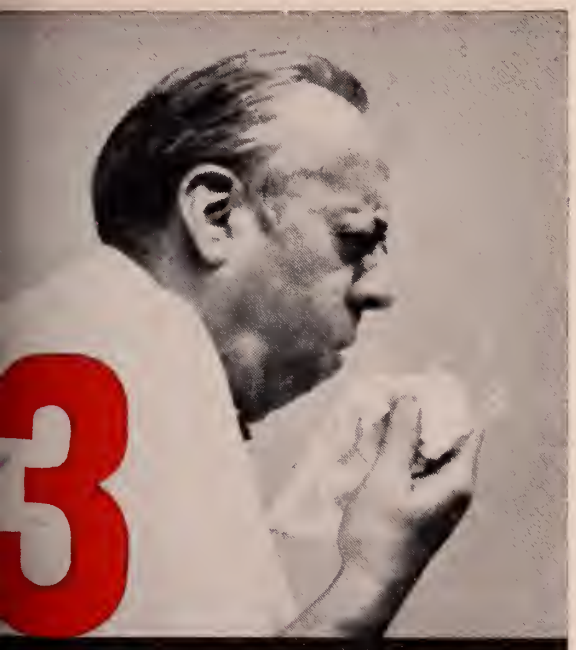
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Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.



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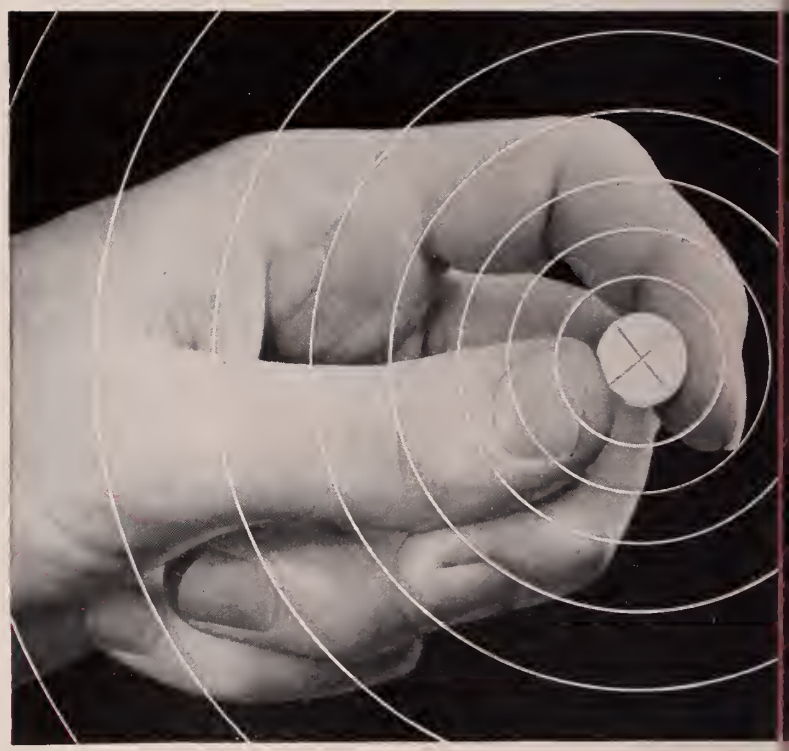
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[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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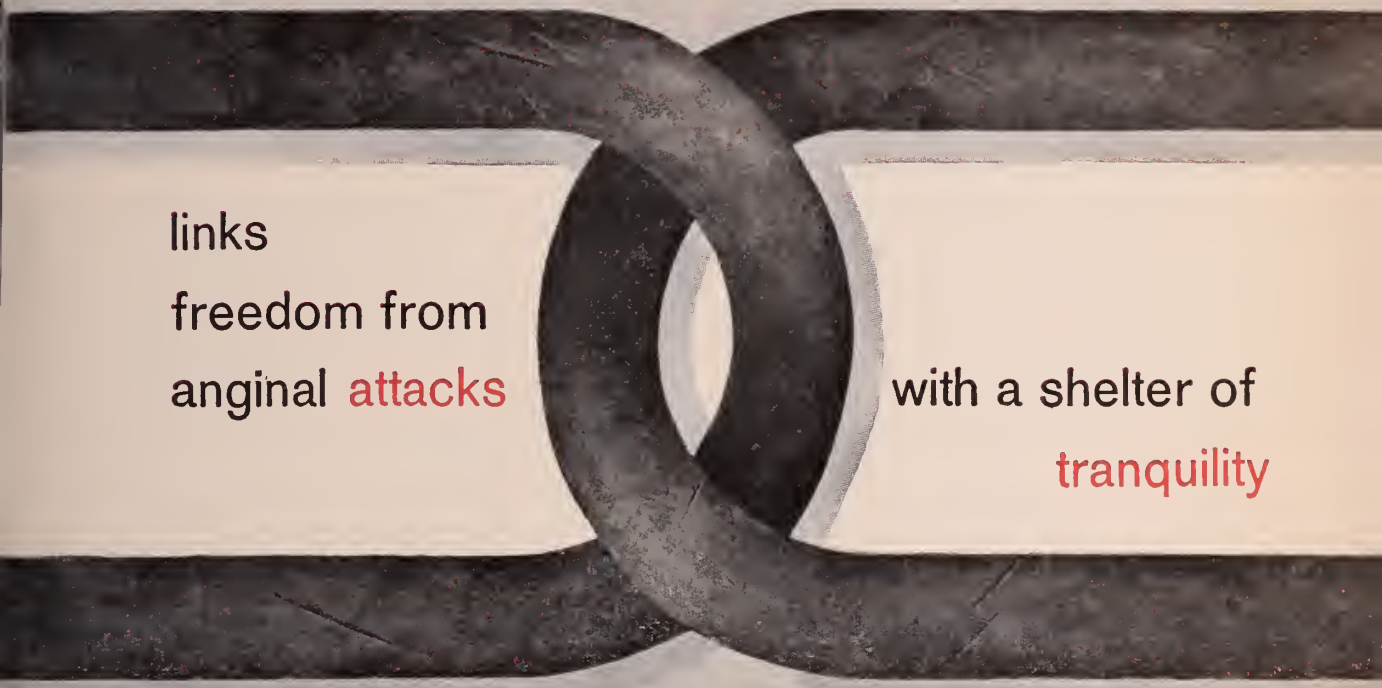
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"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.
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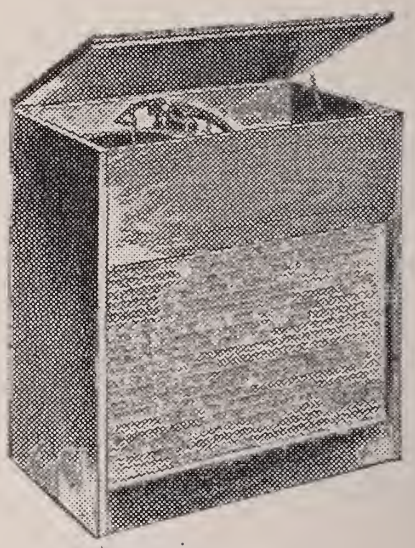
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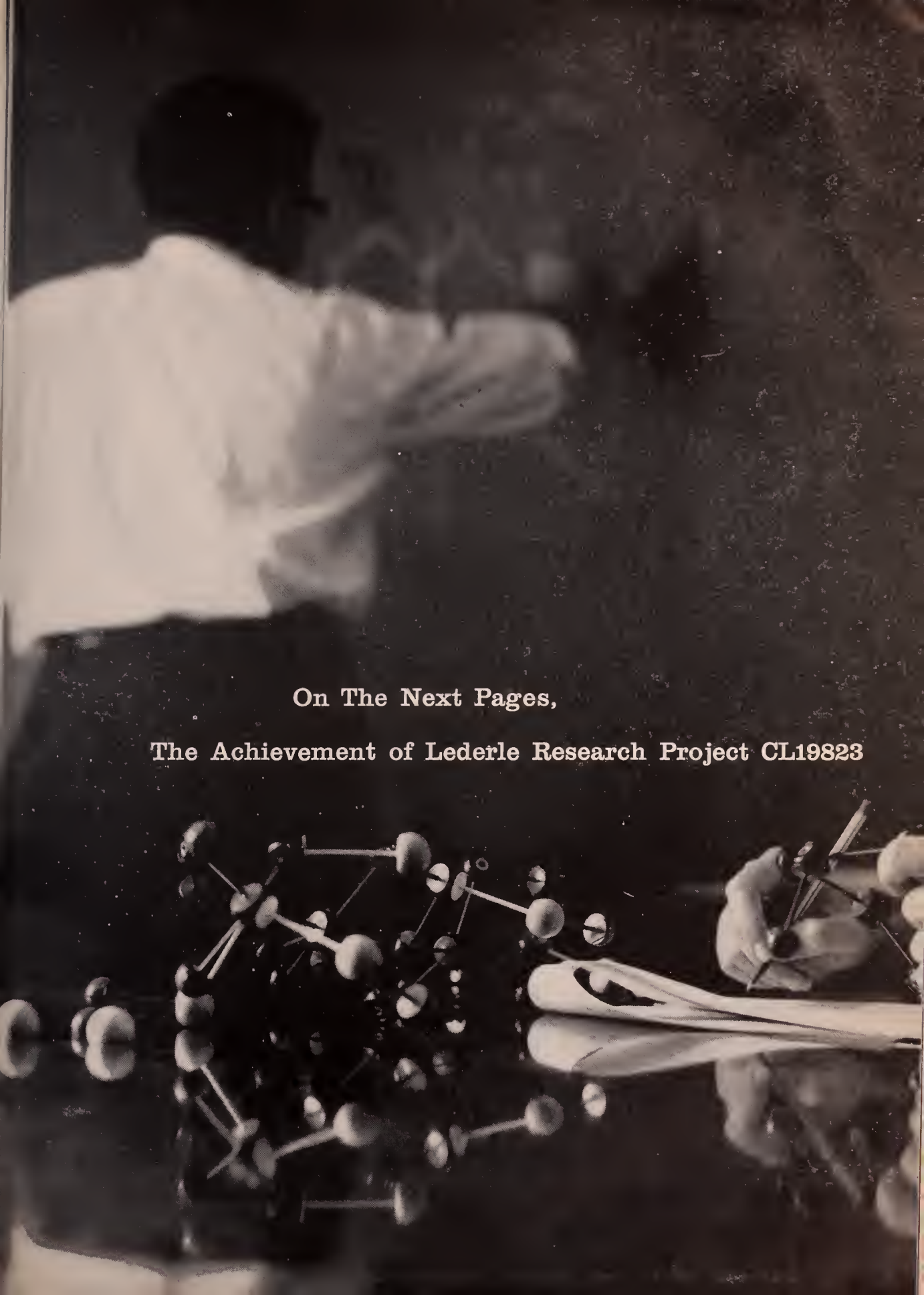


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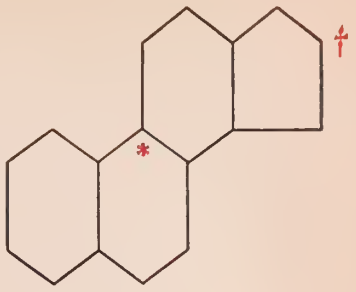
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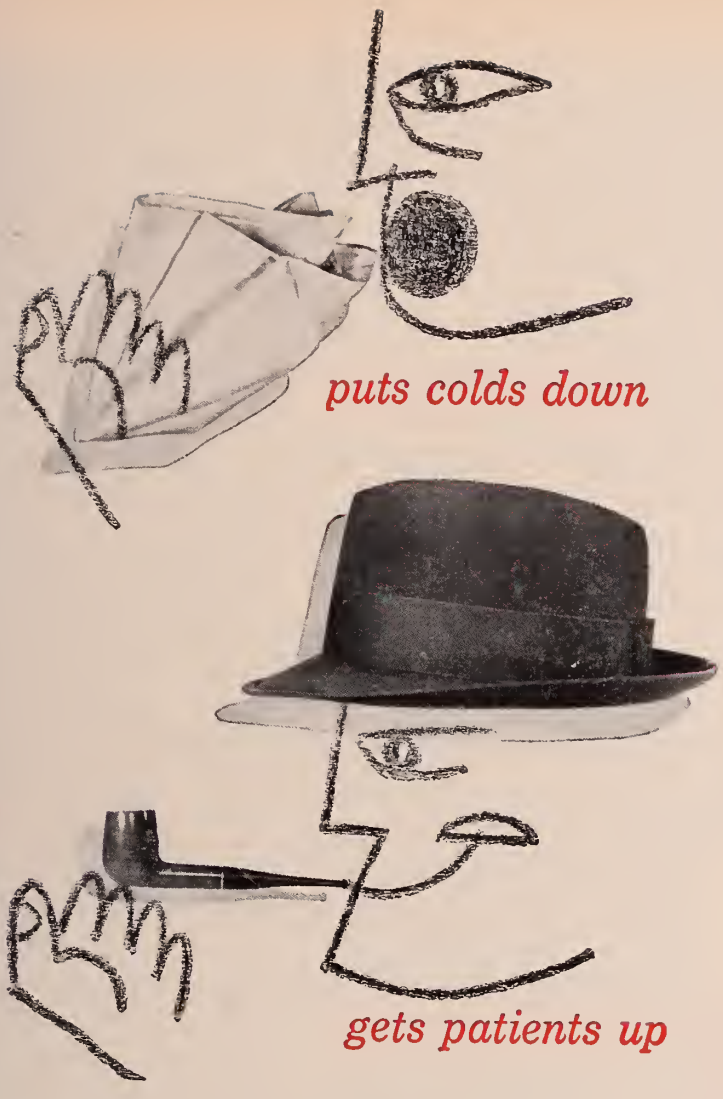
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THE JOURNAL
OF
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Editorials • • •

Antibiotic Combinations

Antibiotics have appeared in such profusion during the past few years that the practitioner has every right to be confused. Sources of this confusion are: the rapid appearance of new antibacterial agents, each purported to be superior to its predecessors, the multiple trade-naming of the same antibiotic, and antibiotic combinations. The combining of two or more antibiotics in a single tablet or capsule, has been the focal point for recent scientific controversy.

Henry Welch [1] touched off the spark at the 1956 Symposium on Antibiotics in Washington. His enthusiastic endorsement of antibiotic combinations stimulated exacting research on this aspect of present-day therapy.

Outcome of these studies is that antibiotic combinations have nothing whatever to add to the treatment of infections (except in tuberculosis and a few relatively rare diseases). They have a great many disadvantages.

Jones and Finland [2] reviewed the evidence in favor of such combinations and found it to be unacceptable on the basis of the data presented. They deplored the commercial exploitation of these unscientific conclusions.

These investigators conducted a number of basic experiments on the antibacterial action of tetracycline in combination with erythromycin, oleandomycin and spiramycin. They found the mixture of tetracycline with erythromycin to be superior to the mixtures of tetracycline with either oleandomycin or spiramycin. However, none of the combinations showed any superiority over the more active single component of the mixture, when that antibiotic was used alone.

They concluded that the use of erythromycin, oleandomycin, carbomycin or spiramycin in mixtures in fixed ratios was inadvisable for the following reasons:

1. Welch, Henry: Paper read at the Fourth Antibiotic Symposium, Washington, D. C., October 21, 1956. Summarized in British Medical Journal, 1:1051 (May 1957).

2. Jones, W. F., and Finland, M.: New England Journal of Medicine, 257:481 (September 12, 1957) continued in same journal, 257:536 (September 19, 1957).

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It encourages inadequate treatment since the same total dose of the combination is used as the usual dose of the single drug, and this does not provide an effective dose of either.

The spectrum of antibacterial agents is reduced because less active antibiotics in smaller amount are delivered than when they are used singly. The combination thus reduces the effectiveness of a specific antibiotic in adequate doses, used judiciously.

Finally, in certain cases they encourage the emergence of resistant strains of microorganisms.

The physician who prescribes antibiotics is advised that the optimum course is to use *specific* antibiotics in appropriate doses for specific infections. The best guides to this are the isolation of the infecting organism and properly executed sensitivity studies.

—R.D.G.

Lay Health Organizations

Elsewhere in this issue we publish an announcement of the establishment of a Tay-Sachs Foundation. This is the last in a long chain of lay-sponsored and lay-financed organizations in the health field. This development, which seems odd to European and Asiatic observers, is a peculiarly American phenomenon. It is recognition of the fact that a medical practitioner does not have the time or money and, let it be confessed, the large scale organizing ability needed to perfect research in many fields of medical science. A century ago research could have been conducted by a dedicated general practitioner using homemade equipment in his basement or his kitchen. But those days are gone forever. Research requires elaborate equipment, extensive teamwork, and high level organization.

The lay health Foundation has other values too. It makes the non-physician realize that he participates in medical research and it brings the healing art problem closer to everybody's door. It is a good public relations medium for the physician and it furnishes a much needed affiliation between the practitioner and the general public.

The most dramatic example of a great good coming out of a lay health organization is the development of Salk vaccine. Strides have also been made in tuberculosis, in cancer research and cancer care, in certain aspects of mental health, and in many other fields because of the fertilization of medical science by community support.

The Medical Care Survey in New Jersey

Most of us are weary of questionnaires and interviews. The Columbia University project to begin next month, however, is in a different category. In the first place, this survey is being conducted by the Faculty of Medicine of a great University. There is no taint of commercialism, self-serving or promotion in this project. The field interviewers are on the staff of Princeton's well known Opinion Research Corporation.

While The Medical Society of New Jersey is not sponsoring the study, we have been fully informed of it and take this occasion to call attention to it. The doctors' anonymity and confidence will be scrupulously preserved.

This project takes a few minutes, or more, of your time. It will advance basic knowledge in this poorly understood field. It recognizes too, that only the physician can make a solid judgment about the quality of medical care. This elementary fact is not everywhere understood, and by making this project a success, you can contribute to such understanding.

Original Articles • • •

Milton E. Landman, M.D.

Rudolph Preisig, M.D.

Maximilian Perlman, M.D.

Bloomfield

A Practical Mood Stimulant¶

The increasing attention being paid to tranquilizing drugs has obscured the fact that we often need the opposite—a stimulating drug. In this study three Bloomfield physicians report on the effects of a piperidine-acetate preparation.

Now that tranquilizing drugs are being developed in ever-increasing numbers with subsequent control of symptoms of hyperexcitability and anxiety, the need for a good stimulating drug has become apparent. Any physician who deals with many patients, particularly in the elderly group, finds a significant number of patients with a dampening effect. This may run the gamut from the mildest loss of alertness to full scale depressive psychosis. These patients are in contradistinction to the, perhaps, more common hyperirritable and anxious people. However, the two are not reciprocally exclusive. Thus, many patients have a mixed emotional reaction in which either the hyperirritable or the depressive phase predominates. This, of course, is most apparent in the dramatic cycles of the manic depressive psychosis.

Up to the present the treatment of patients with functional depression has for the most part been unsatisfactory. This is even more true of the most severe type—the depressive psychosis. Here shock therapy appears to be the only effective treatment. In milder cases several compounds have been in extensive use for the alleviation of the depressed state. Chief among these have been drugs in the amphetamine group and in the caffeine group. The amphetamine category includes amphetamine and dextroamphetamine as well as a large variety of chemical derivatives having a definite mood elevating effect. Unfortunately, this is attended with a number of undesirable actions, including anorexia. While loss of appetite may be desirable in many cases, it certainly has no role in the depressed patient, who is usually already anorexic. Another important undesirable effect in many is the sympathicomimetic action of the amphetamines. Side reactions such as palpitation, agitation, tremors, tachycardia, and blood pressure elevation are often seen. In addition, delirium and insomnia as well as sudden loss of drug action with the so-called "letdown" phenomenon is often noted. Caffeine, being a central nervous stimulant acting on both the medulla and the cortex — the strongest of the xanthines in this regard—is no longer frequently prescribed as such. It is used extensively by every individual

¶ This work is from the Essex County Hospital at Belleville and St Vincent's Hospital in Montclair.

in his ordinary diet, so that its stimulating action varies considerably from person to person. Even with caffeine, some people exhibit side effects such as tachycardia, delirium or gastro-intestinal distress. Strychnine, picrotoxin, nikethamide,† metrazol and camphor all are capable of central nervous stimulation but have almost no value in the treatment of the functionally depressed patient.

Methyl-a-phenyl-2-piperidineacetate hydrochloride (Ritalin®)* belongs to the group of aromatic and heterocyclic compounds of fatty acid esters. Studies in animals showed it stimulates the psyche as well as increasing coordinated movements or motility. It has an analeptic effect against some narcotics and stimulates the respiratory center particularly when depressed by such narcotics. In animals there is a slight increase of heart rate and blood pressure but without simultaneous peripheral sympathicomimetic effects. Maxwell *et al.*[1] found Ritalin® blocked the pressor responses due to carotid occlusion and that produced by amphetamine or ephedrine. They concluded that besides being a central nervous stimulant, it has some centrally mediated antihypertensive properties. In animals its toxicity is equal to that of caffeine.[2]

Ferguson and Funderburk[3] reported on 215 women over 60 years of age. Following oral administration of Ritalin® and/or reserpine, they felt that definite benefit was obtained in this senile group. Madi and Kovitz[4] studied 41 psychotic patients and found clinical benefits in 90 per cent. Ferguson *et al.*[5] reported on the use of an injectable solution in 11 psychotic patients with placebo control. A clear differentiation was observed in all. Zahn[6] obtained good results in 24 of 48 senile patients. Stier[7] used the drug in conjunction with electroshock therapy in 117 depressed patients with good results. Drassdo and Schmidt[2] write that pulse rate and blood pressure were somewhat elevated in some patients and circulation time was accelerated. These findings were not noted by other investigators.

The drug is also available in combination with reserpine and with tripelennamine. The former combination is tradenamed Serpatilin® and the latter is Plimasin®. These combinations are reported[8,10] as successful in overcoming the drowsiness occasionally associated with the primary drug.

*Supplied for this study through the courtesy of J. Campbell Howard, Jr., M.D., of Ciba Pharmaceutical Products, Inc., Summit, N. J.

† Nikethamide is usually prescribed under its Ciba tradename of Coramine®.

METHOD

In this study an attempt was made to determine the efficacy of Ritalin®. The double blind technic was used. We gave a placebo or the active drug for periods of 4 days each. Ritalin®, 10 milligrams, or identical placebos were given three times a day. Neither the patients nor the investigators knew which drug was being given at any time until the study was completed. The patients were divided into three groups. The first consisted of 23 control individuals drawn from the nurses and personnel of a general hospital. They had no particular complaints and were in good health. The second group consisted of 28 patients drawn from a general hospital and private practice. These were suffering from mild depressive or "down in the dumps" symptoms secondary to relatively short term organic illnesses. The third group consisted of 61 elderly chronically ill patients from an institution for the care of the indigent chronically ill. Symptoms in the last two groups consisted of lethargy, fatigue, emotional depression as manifested by crying spells, chronic complaining and resistance to rehabilitation.

RESULTS

In Table 1 are tabulated the effects of Ritalin® as compared to the placebo in all three groups as well as the entire group. In the control group, 83 per cent showed marked effect, and 17 per cent no effect. In Group 2 (the general hospital and private practice group) obvious drug effect with mood improvement occurred in 64 per cent, questionable effect in 11 per cent, and no effect in 25 per cent. In the third, the large geriatric group, 61 per cent showed marked improvement, 11 per cent possible improvement, and 28 per cent no improvement. For the entire 112 patients, 66 per cent showed marked improvement, 9 per cent possible improvement, and 25 per cent no improvement.

TABLE 1. EFFECT OF RITALIN® COMPARED TO PLACEBO

	Marked		Possible		None		Total
	No.	%	No.	%	No.	%	No.
Group I	19	83	0	0	4	17	23
Group II	18	64	3	11	7	25	28
Group III	37	61	7	11	17	28	61
Combined	74	66	10	9	28	25	112

Marked means obvious drug effect and mood improvement.

Possible means that the effect is not clearly differentiated from the effect of the placebo.

None means that there was no statistically meaningful difference between the effect of the placebo and the effect of the Ritalin®.

COMMENTS

Comparison of the results in the individual groups to one another (Table 1) by the chi-square method show there is no real difference in the proportion of patients responding. This seems to confirm the validity of the methods employed as there was no particular difficulty in determining the reactions in the first group of patients.

As a further check, the statistical significance of the number of patients showing improvement was determined (Table 2). There was a 25 per cent probability that the patient on Ritalin® would be judged improved, irrespective of objective evidence. The significance of the percentage of patients on Ritalin® who were actually judged to be improved is related to this chance probability of 25 per cent. To obtain effective calculations, the "possible group" in Table 1 was transferred to the "not improved group." Despite this, it was gratifying to find statistically significant difference in favor of the drug over the placebo in all three groups as well as the entire series.

TABLE 2. SIGNIFICANCE
Double Blind Comparison: Ritalin® *vs.* Placebo

	Number of Patients	% Definitely Improved	% Not or Only Possibly Improved	Significance
Group I	23	83	17	0.005
Group II	28	64	36	0.005
Group III	61	61	39	0.005
Combined	112	66	34	0.005

Regarding the third or geriatric group several significant comments may be made. These patients as a whole were extremely deteriorated. The average age was 71. The largest group consisted of patients with arteriosclerosis and its complications, the second largest of various types of carcinoma. In the younger patients, diagnosis included advanced multiple sclerosis, epilepsy, bronchial asthma, and inoperable carcinoma of the colon. If we remove these young cases the average age becomes 75. It was particularly difficult, therefore, in this group to observe clear-cut changes. Where there was any doubt, findings were always placed in the "possibly improved" or "not improved" categories.

It was also for this reason that in determining statistical significance (Table 2) all cases in the "possibly improved" group were transferred to the "not improved" group.

No serious side reactions were noted in any of the patients. Minor reactions, including insomnia, restlessness and slight tremor, were seen in 8 cases (Table 3) representing 7 per cent. In no case was it necessary to stop the drug. No evidence of significant effect upon blood pressure or pulse has been found. This is particularly interesting, since these side effects have been common with other mood elevating drugs such as the amphetamines and caffeine.

TABLE 3. SIDE EFFECTS

Side Effects	Group I	Group II	Group III	Combined
Insomnia	1	1	1	3
Restlessness	0	2	0	2
Slight Tremor	1	1	1	3
Total	2	4	2	8

In spite of the limitations necessitated by the double blind procedure where dosage cannot be individualized, good results were obtained.

SUMMARY

A double blind study of the mood elevating properties of Ritalin® in 112 patients showed statistically significant effect. The series con-

sisted of 3 groups with 23 healthy control individuals, 28 patients with mild depressive symptoms secondary to short term organic illnesses and 61 elderly, chronically ill patients with symptoms such as lethargy, fatigue, emotional depression, chronic complaining and resistance to rehabilitation. This drug offers great help in patients in whom elevation of the mood is desirable.

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Hospital Visitors

Few healthy people realize how exhausting a visit may be for a patient, particularly if the visitor is of the energetic type talking away hard in a loud voice usually about himself and with little thought for the invalid. Patients often look deceptively well, particularly to a lay person. A man 48 hours after a coronary thrombosis or a woman two or three days after parturition may look practically normal, so that the visitor stays on talking and trying to cheer him up when all the patient wants is to be left alone. In wards, visiting is usually limited, but in private rooms, the patient, no matter how much he pays, may be denied solace. Indeed in private pavillions, one booming visitor may follow another until the patient is talked into coma. Doctors should be more exact in proscribing visitors till the patient is able to cope with them; and the length of the permitted visit should be defined. On the other hand, a mother or husband just sitting near the patient but rarely speaking may be a great solace. In these days of shortage of staff a relative can do much to help the patient in little ways, such as passing drinks or raising pillows. This is especially true with children, where the mother can feed and attend to the child and give her whole attention in a way no nurse could. Children require emotional support in an emergency and the mother is the most effective prophylactic against psychic trauma because she provides the normal emotional environment for the child. There is much to be said for admitting the mother with a young child whenever possible.—F. F. Hellier, M.D., Patients' Relatives as Hospital Visitors, *University of Leeds Medical Journal*, February, 1957.

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Primary Closure of the Exstrophied Urinary Bladder*

For exstrophy of the bladder, the urologist usually thinks first of urinary diversion into the lower gastro-intestinal tract. However, nothing is lost by trying primary closure with an attempt to infold the bladder back into the abdomen. And if this is successful, the patient is much better off.

Exstrophy of the urinary bladder, reportedly only one in 40 to 50 thousand births, is nevertheless a major urologic problem. It occurs more frequently in males than in females. In the past, methods of handling these patients were directed towards diversion of the urine to the colon by ureteroenterostomy and subsequently a cystectomy and abdominal closure. The problems incidental to this type of management include renal infection, ureteral stricture, hyperchloremic acidosis, rectal incontinence of the urine, and ureteral calculi. These have all contributed to the morbidity of these patients.

Complete separation of the urinary system and the gastro-intestinal system is the treatment of choice. The table summarizes the methods of management of bladder exstrophy at the Columbia-Presbyterian Hospital from 1928 to 1956. We try to restore the normal anatomic condition of the urinary tract in these patients with its complete separation from the fecal contents. When an ileal bladder or rectal bladder with proximal colostomy is used as a method of diversion, a prosthesis must be worn but these patients are, in general, clinically better than the patient who has a ureteroenterostomy.

Primary closure of the urinary bladder and restoring it to an intra-abdominal position in no way precludes the subsequent use of a substitute bladder and as such should be the first treatment of choice for exstrophy of the bladder.

TECHNIC

In general, the technic used at the Columbia-Presbyterian Hospital is the same as described by Dr. Sweetser in his original articles[1] and consists of freeing up the bladder

BLADDER EXSTROPHY
METHODS OF URINARY DIVERSION
1928 - 1956
COLUMBIA-PRESBYTERIAN HOSPITAL

	Patients
Coffey I Ureteroenterostomy	18
Modified Maydl Ureteroenterostomy	9
Modified Maydl plus Colostomy	1
Nesbit Ureteroenterostomy	1
Goodwin open transcolonic Ureteroenterostomy	2
Sweetser Primary Bladder Closure	8
Total Patients	39

*Read May 1, 1957 at the Annual Meeting of The Medical Society of New Jersey at Atlantic City.

1. Sweetser, T. H. *et al.*: Journal of Urology, 75:448 (March 1956)

and urethra and infolding them into a sac and tube. A strand of muscle and fascia is reflected from the top edge of the pelvic diaphragm. This strand is wrapped around the new urethra at the bladder neck in an effort to form a sphincter. The prepuce may be used as a tube to make the urethra reach the tip of the glans penis. However, this is not always needed. In freeing up the bladder and forming the bladder sac the peritoneum is not reflected too extensively and a perineal traction suture is not used. This is done to avoid devascularizing the bladder and denuding the ureters. The obliterated hypogastrics are crossed over the bladder to aid in keeping the bladder within the abdominal cavity. A Malecot suprapubic catheter No. 22 is usually inserted in the dome of the bladder until healing is complete. A urethral catheter may be left for 24 hours as a splint or removed immediately after operation after forming the urethral tube over the catheter. The fascial defect is bridged by flaps of anterior rectus which are folded over in front of the bladder in a double-breasted closure. The skin and subcutaneous tissue are closed by the Z-plasty technic.

RESULTS

All of our patients were done between the ages of three months to three years. In this total number of eight cases, all still remain incontinent. In several we are able to now note prolonged periods of continence and gradual increase in bladder capacity. It is still too early to evaluate the functional capacity of these bladders. Several of the patients are able to void a urinary stream. Four patients had urethral strictures which require periodic dilatation. Another problem which appears to be incidental to this operation and, we believe, characteristic of the exstrophied bladder has been ureteral dilatation and some ureteral reflux. In the modified Maydl ureteroenterostomy where the entire trigone or the bisected trigone is implanted into the rectum, reflux was also a common finding appearing in five out of ten patients. The upper urinary tracts in patients with primary bladder closure must be watched carefully and one of our patients who had postoperative ureteral dilatation has shown now in his follow-up studies, three months postoperatively, reversion to a normal intravenous pyelogram. Urethral fistulae incidental to the epispadias repair also present a problem but not an insurmountable one. In one patient there was sloughing of the rectifascial flap and subsequent plastic procedure had to be done. It appears that operating on these patients at an early age permits somewhat better chance of complete closure. In our group, the children done from 3 to 6 months of age did better than those from 2 to 3 years of age.

SUMMARY

Exstrophy of the urinary bladder should have the benefit of at least one attempt to infold the bladder back into the abdomen by primary closure. Nothing has been lost by this operation and nothing has been destroyed in an attempt to duplicate Nature's own pattern for the design of the urinary tract. Urinary diversion can still be done at a later date into a segment of ileum or a rectal bladder with proximal colostomy if the primary closure proves unsatisfactory. Those patients with complete separation of urinary and fecal streams are not plagued with either acidosis or infection which will decrease life expectancy. The superficial operation of primary closure does not have any intraperitoneal point of union of ureter and colon and thus excludes the dangerous possibility of intraperitoneal leakage of urine. The technic of primary closure is most appealing to the parents of these children who, of course, desire any effort that can be directed toward attaining normalness in these unfortunate children.

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Verucca Vulgaris*

A SIMPLE TREATMENT TECHNIC

Tincture Thuja (Homeopathic Pharmacopoeia) has been used for the treatment of warts since 1819. It has been neglected in the past half-century in favor of mechanical, surgical, systemic and psychotherapeutic methods. Dr. Kline here reports a recovery rate of 82 per cent by applying the 10 per cent tincture twice a day.

Warts will here be considered as one group,[1] namely, the common wart, periungual warts, plantar warts, flat warts and mosaic warts. The same virus is thought to cause all types of warts, although Lyell and Myles[2] have recently suggested the existence of two different viruses.

The treatment of warts has been as varied as that of any other disease, and as successful as the enthusiasm of the practitioner applying the treatment. The successful treatment of warts may be an art. The physician must recognize and take advantage of the spontaneous disappearance of some lesions as well as the effects of suggestion. Most dermatologists think that suggestion is the prime reason for the success of many methods of treatment. Baird,[3] however, says that he has never seen a case cured by suggestion. Perhaps those who claim such a cure may, in fact, be seeing cases of spontaneous disappearance which happened to be preceded by the various attempts at treatment by suggestion or charming.

Bloch[4] and his co-workers attempted to evaluate the results of psychotherapy. They blindfolded 228 patients and, in the presence of an electric machine used for its sound effects, tinted the warts with various colored liquids. After several months' observation, they reported an over-all cure of 55 per cent. Memmesheimer and Eisenlohr[5] followed two groups of children with warts. One group received suggestion therapy and the other was merely observed. They reported the same number of recoveries in each group. Curiously, only a fourth of the patients were cleared after many months of observation. This is considerably *below* the proportion of cures to be expected even by spontaneous remissions.

Systemic treatment is advocated by many dermatologists. The favored preparation is some form of bismuth, given orally or by injection. There is considerable variation in the effectiveness of this method—and it seems to

*Presented April 30, 1957 to the Dermatology Section of The Medical Society of New Jersey at its Annual Meeting.

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vary more with the reporting author than with the preparation used. For instance, Baird [5] said he cured 35 out of 36 cases (a recovery rate of 97 per cent!) by using a soluble bismuth, namely, sodium bismuth thioglycolate intramuscularly twice a week. Lunsford [6] and others described 15 successful removals and 32 failures (a success rate of 30 per cent) with an insoluble bismuth. Allington [7] treated a group of cases with injections of distilled water and another group with injections of sulpharsphenamine and reported 48 per cent cures in the former and 52 per cent in the latter. This difference is not statistically significant. It would not justify subjecting a patient to a possibly toxic substance. Biberstein,[8] reported 80 per cent cures with the use of a specific vaccine, yet Brain,[9] Findlay [10] and others have said that vaccine therapy has no specific value in the treatment of warts.

Other methods advocated include roentgen therapy, specific cell poisons, such as podophylline, surgical excision, electrodesiccation, freezing with carbon dioxide, liquid nitrogen and oxygen, chemical destruction with trichloracetic acid, phenol, formalin, nitric acid, silver nitrate and salicylic acid. In properly selected cases, any one of these may be considered the remedy of choice.

In the cases below presented, a degree of selectivity was used. Criteria included: the presence of excessive number of warts, presence of warts in locations in which other methods of treatment are impracticable or inadvisable, such as subungual region, nail wall and multiple plantar warts; presence of warts resistant to other methods of treatment which at first seemed more convenient or more desirable and finally the recurrence of warts following the administration of other treatments.

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MATERIAL AND METHOD

The preparation here reported on is Tincture Thuja, USP (Homeopathic). *Thuja occidentalis* is an evergreen tree growing in North America, common from Pennsylvania northward. The fresh leaves and twigs are used to prepare a 10 per cent tincture,[11] in alcoholic solution. Although Thuja has been recommended for the treatment of warts at least since 1819, I have been unable to find earlier references to its effectiveness.

The tincture is applied to each wart twice a day for at least two months. The patient must be reminded never to miss an application. It has been thought by some that this insistence is based on its psychologic effect, but this emotional factor has not been demonstrated.

RESULTS

Since this series of cases was obtained from private practice, it was not possible to develop a controlled experiment using placebos or matched controls. However, it does seem that the proportion of cures is so high as to suggest that the preparation was responsible for the results. As indicated in the table, the largest number of cases was the common wart with a recovery rate of 83.5 per cent. The number of plantar warts, mosaic warts and juvenile warts was too small to be of statistical value, but they too showed an over-all cure rate of 66 per cent. The rate of cure for the entire series was 81.5 per cent, which is certainly higher than the usually accepted figure of 50 per cent spontaneous cures. This figure of 50 per cent does not, however, represent a universally accepted opinion.

In most cases the warts disappeared gradually usually between the 6th and 8th weeks. In a few cases there was a complete cure in six weeks, in several other cases the time was ten weeks. More than four-fifths were cured within two months. In a few cases there was a

sudden itching sensation, after about the sixth week of treatment, with an abrupt disappearance of all warts over night. In no case was there any recurrence of the warts in the previously involved areas. In most of the unsuccessful cases, the patient was not diligent in carrying out the instructions as prescribed. In two of these cases the warts completely disappeared after cessation of treatment, at the end of one year. These cases were still classified as failures.

The great advantage of this method, when successful, is the ease of treatment, the lack of pain and the absence of any scar formation.

CASE ONE

A six-year old boy had 75 warts on the dorsum and palmar surfaces of all the fingers and hands, the lips and forehead. These warts had been present for over one year. Tincture Thuja was started on May 9 and by July 25, every wart had disappeared, without leaving any scars. This illustrates this method in multiple lesions and the marked scarring that would have occurred if destructive methods had been used.

CASE TWO

A 35-year old Naval officer had numerous verrucous lesions on the bearded region. He had been treated by many methods, including chemical destruction, electrodesiccation and bismuth. He was despondent about the failure of all these attempts at treatment and was rather skeptical about the success of this suggested method of using a local application. Eight weeks after the first application of Tincture Thuja, he noticed a sudden itching and burning of all lesions on the face and woke up in the morning with all the warts gone. This illustrates the success of this method when many other methods had failed.

CASE THREE

An 18-year old girl had a large mosaic wart covering the entire plantar surface of the left big toe and adjoining sole of the foot. She was attending college in Virginia. There, attempts at destruction by electrosurgery and surgery resulted in failure. This caused so much pain that she was forced to leave school and return home to Atlantic City. Treatment with Tincture Thuja began on January 31. On February 24, less than four weeks later the wart was almost entirely gone and at the end of six weeks it was completely healed. She returned to school and was able to finish the semester without recurrence. This shows the usefulness of this method in such large lesions as mosaic warts and suggests the success that may occur after failure of other methods of treatment.

CASE FOUR

A 32-year old dentist had eight small plantar warts scattered over the sole of the left foot. Eight weeks after the first application of Tincture Thuja, all lesions had disappeared. This illustrates the use of this method in multiple plantar warts, where x-ray therapy was not feasible and a satisfactory method of treatment is always a problem.

CONCLUSIONS

A SIMPLE method of treating warts, with the local application of Tincture Thuja, has been presented with an overall cure rate of 82 per cent. Although adequate controls were not set up, it is felt that this remedy deserves further study, especially in selected cases of warts that present difficult problems because of multiplicity of lesions, awkward location or the failure of other methods.

Case	Type of Wart	Result at End of 10 Weeks Recovered	Failure	Recovery Percentage
67	Common warts	56	11	83½
5	Plantar warts	3	2	60
2	Juvenile warts	2	0	100
2	Mosaic warts	1	1	50
76		62	14	81½

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Beetles in the Ear

Much of the daily practice of medicine consists in little things . . . minor complaints, brief illnesses, simple treatments. But most of the medical literature concerns rare diseases, major illness, complex therapies. Here, with no words wasted, is a simple report on a troublesome little ailment.

My consulting service (W. F. Prior Company, Inc., Hagerstown, Maryland) reports no literature indexed under subject of *Serica sericea* in the ear. Therefore, I shall outline what I know about it. My experience was at the Boy Scout Jamboree at Valley Forge, where I worked as a medical officer. During the first three days we had seven cases out of fourteen hundred boys under our care. In the entire encampment of 56,000 boys, it was estimated that there were over two hundred cases.

The patient awakens from sleep with an agonizing pain in one ear. Usually he had been sleeping outside.

The signs include: a blood-filled external auditory canal in a patient who did not previously have evidence of illness. No fever is noted until two or three days later in neglected cases. There is so much blood the beetle cannot be seen until after thorough cleaning. We used an oil anesthetic, tradenamed as Auralgan® (Doho Chemical Corp., New York) which is a solution of benzocaine and antipyrine in glycerol. This promptly smothered the beetle and stopped the pain. The insect could then be removed by means of a spiral dental burr, such as is used to remove the tooth root.

On examination, the doctor finds that the external canal is excoriated by the sharp leg horns. The ear drum is edematous and the handle of the malleus is hemorrhagic.

Prophylaxis consisted of tying a cloth securely over the head and ears.

Serica sericea is commonly called "June Bug," not to be confused with the "May Beetle" which is a much larger related genus. It is the size of a pea and fits snugly into the external auditory canal. It is attracted to white light. It spends three years under ground in its larva state. Every three years, it is more abundant than in the intermediate years. Thus, 1957 was a bountiful year and other good years* have been 1954, 1951, 1948 and so on. They do appear every year, most prevalently in June, and in all parts of the world. The bug is capable of a rather sharp nip if held in the hand. No blister or hive results. Other considerations relate to domestic animals and a possible disease vector which has not yet been investigated.

Acknowledgments: J. Carlisle Brown, M.D., Alfred R. Henderson, M.D., Harold N. Moldenke, Ph.D.

*From the beetle's point of view.

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ITS RELATION TO THE GENERAL PRACTITIONER

Many patients in our mental hospitals need their beds only to sleep in. They do need the hospital's day-time facilities, but at night they can snore as peacefully in their bed-rooms at home as in the expensive, tax-supported beds of the public institution. Why doesn't somebody do something about this—and let those patients sleep home? Somebody has. Dr. Harold Magee and his staff at Trenton, for example. Here's how.

The Day Hospital is a relatively new development in psychiatric care. Its primary purpose is to provide a facility for a comprehensive treatment program, to meet the needs of selected patients who are sufficiently incapacitated to warrant the benefits offered by hospital service and yet are well enough to remain at home part of the time. Patients in this borderline group present a familiar problem to most physicians. They frequently are not amenable to routine out-patient treatment. However, they are usually reluctant to accept hospitalization, particularly in a state hospital. Their presenting problems are varied and multiple. Characteristic is their failure to sustain a satisfactory adjustment in one or more major areas of life: family, social, economic, physical health and sexual. All reveai some manifestation of anxiety. This may take the form of symptomatic neurotic reaction, hypochondriasis, somatization or partial resolution in a psychosis. Few have any significant awareness of the role that this anxiety plays in relation to their symptomatology. These patients still turn first to the family physician for help. When more intensive psychiatric care is needed, it is his task to interpret this to the patient and to the relatives. In most instances, he will also continue to care for the patient after this treatment has concluded. The Day Unit at the New Jersey State Hospital at Trenton is an example of an additional community resource available to the general practitioner in the management of these patients.

A specialized facility of this type was first instituted at the Adams House,[1] Boston, 1936, with the establishment of a "Day Sanitarium to serve the function of co-ordinating consulting clinic services with rehabilitative and educational facilities of the house on a non-resident basis or schedule." The Day Hospital of the Allan Memorial Institute in Montreal, Canada, was opened in 1946. It was, at this time, that the purposes, form and function of this type of Unit were first clearly defined by the Director of the Institute, Dr. D. Ewen Cameron.[1] His contributions have been incorporated into other hospitals of this type and are particularly pertinent to the development of the Day Unit at the Trenton State Hospital. Dr. Cameron ob-

*Read April 30, 1957 before The Medical Society of New Jersey.

1. Cameron, D. E.: The Day Hospital in The Practice of Psychiatry in General Hospitals. (In Press)

serves that psychiatric services, in the main, have attempted to conform to and in some instances unnecessarily duplicate the ideas expressed in the operation of the general hospital. He suggests three basic explanations for this trend. First, the desire of the psychiatrist to be accepted by his medical colleagues and to conform to existing standards of medical practice. Second, an almost magical hope that the application of the same practices employed in a general hospital would produce the same excellent results. The third and more practical motivation involves the problem of acceptance by the patient and his relatives of the idea that emotional disorders constitute an illness, and like any other illness should be treated. Dr. Cameron suggests that we review the premises which underline the organization of a general hospital before we incorporate them into the psychiatric division of the hospital.

THE first premise to be examined is the use of the *bed* as a standard unit for treatment. While the internist and the surgeon can conveniently think of an equation between beds and patients, most psychiatric patients require beds only to sleep in, not as a treatment area. The psychiatrist, on the other hand, is primarily concerned with those areas in which interpersonal relations are conducted. In terms of structure, this includes consultation rooms, day rooms, occupational, recreational areas and even the home. It becomes obvious that implementing this concept alters the structural design and staffing pattern of the Unit.

The second premise of the general hospital is that it is for the patient alone that therapy is primarily designed. But this is not entirely applicable in the psychiatric setting. Here the patient is considered to be a member of a constellation of figures, primarily the family group. These people and the transaction processes that occur between them must be dealt with if we are to gain a comprehensive view of the patient and his disorder. The third premise that Dr. Cameron challenges concerns the concept of "cure." While we ordinarily think of the patient as going to a hospital to get well, the psychiatric patient goes to the hospital to get well enough to return to the community and continue the process of rehabilitation and re-adjustment. This type of Unit offers corollary advantages from an economic standpoint. For example, there is a reduction in nursing service — one shift instead of three, the food service—one meal instead of three, and in laundry maintenance, and so forth.

In 1948, Bierer [2] established a "social psychotherapy" center in London, England. This center has been concerned with the study and development of social psychiatry and psychoanalytic psychotherapy. They [2] have stressed the multi-dimensional approach to treatment.

In 1949, the Menninger Clinic opened a Day Hospital in which the patients resided downtown and commuted to the clinic daily for treatment. In 1950 a second Day Center was opened at Montreal General Hospital, similar in structure to that of the Allan Memorial. In 1952 Dr. Magee, at Trenton, inaugurated the first Day Unit associated with a state hospital. Subsequently, other Day Units have been developed operating on a similar plan. The Maudsley Day Hospital was opened in May 1953. New York [3] opened the first of two such Units in June 1956.

There is, as yet, no official listing of this type of psychiatric facility. However, during the past 21 years increasing experience has been gained and it would appear that other such Units can be expected to be established. They may operate separately or in conjunction with an in-patient service. The advantages of the former are largely associated with the avoidance of a hospital atmosphere. It would, however, be a more costly operation than the latter, with its inherent economy of fixed facilities for in-patients such as consulting services, laboratories, x-ray, occupational and recreational areas. There are of course occasions when it is advisable to have the patient under 24-hour supervision.

The organization, structure and function of a Day Unit at the Trenton State Hospital are designed to implement the principles innum-

2. Bierer, J.: The Day Hospital: An Experiment in Social Psychiatry on Syntho-Analytic Psychotherapy. H. K. Lewis and Co. Ltd., London (1951).

3. Harris, A.: The Hospital; April (1954).

erated by Dr. Cameron. It is common practice to speak of type of service, physical structure, administration, staffing patterns, treatment program, teaching, research and public relations as separate considerations. Actually, they are so closely interrelated that in this setting it must be acknowledged as an artifice of descriptive writing. The type of service logically determines all other factors.

THE patients in this service fall into two major categories: those who are voluntarily admitted from the community and returned to their homes in the evening and, those who are resident convalescent patients who have been recommended for additional intensive rehabilitation as a transition phase between the hospital and their return to the community. The Unit is co-educational and admits all age ranges from adolescence to the older age groups. All patients are socially incapacitated to the point where they are unable to continue their usual vocational and occupational pursuits. The diagnostic categories include severe psychoneuroses, psychophysiologic disorders and psychoses. The heterogenity of this group places obvious limitations upon the selection of patients. In general, persons with suicidal, homicidal and destructive trends are not admitted. Since the patients themselves are part of the therapeutic process, certain other disrupting forms of behavior are excluded because of their adverse effect on group unity. Thus, we exclude those who act out markedly antisocial psychopathic traits, the severely masochistic, sadistic, or persecutory patient, the extremely hyperactive, affective or schizophrenic patient and the severely deteriorated neurologic and organic brain disorders. It is generally agreed that the most effective groups are those limited in size to 20 patients. We have found that in addition to a maximum there is also an effective minimum. In our experience, the group that falls below eight patients also tends to be less efficient. The capacity of the present Unit is 12.

Administratively, the Day Unit functions as a separate service within the hospital. Its policy is to provide the maximum utilization of all applicable treatment resources including physical facilities, established therapeutic modalities, and the social interaction of staff, patients and relatives. The Unit is open Monday through Friday from 8:30 a.m. to 4:30 p.m. Some patients have to be escorted to and from the hospital; others travel by public transportation. For practical purposes admission is limited to patients who reside within one-half hour traveling time from the Unit. The cost is the same as for any other patient in the hospital. The maximum charge is fixed by law and arranged through the County Adjuster's Office.

THE present Unit occupies a seven room apartment away from the other hospital wards. During operating hours the doors are unlocked. It has recently been redecorated through the combined efforts of the hospital, the volunteer aids and a public spirited citizen who obtained the support and material contributions from local merchants. It now has the appearance and all the conveniences of a comfortable, well appointed home, although requisite areas referred to previously are included in the structure.

The Staff is organized as a psychiatric team, *e.g.*, supervising psychiatrist, psychiatric resident, nurse, attendant, affiliating nursing students and part time representatives of the cooperating ancillary services, psychology, social service, occupational, recreational, educational, bibliotherapy and volunteer aid. The psychiatric resident, nursing students and technicians are assigned in rotation as part of their clinical training. Informal team conferences are held daily to provide continuity between the weekly staff meetings. These meetings offer an excellent opportunity to observe the patient's reactions in several settings and to different people. It also provides a supportive atmosphere for the members of the staff to examine their own attitudes toward patients, relatives and each other.

While all members of the team are unquestionably important to the success of the Unit, the two pivot points are the supervising psychiatrist and the psychiatric nurse. The highest

degree of co-operation between these two individuals is essential. The supervising psychiatrist functions as administrator, therapist, instructor and research investigator. The psychiatric nurse, because of her greater contact with patients, is generally regarded as the "key figure" in the group. Her duties have been defined elsewhere [4] as (a) captain of the ward team (b) teacher and (c) group leader. Her responsibilities as captain of the ward team extend beyond supervisory activities. With her rests primarily the all important responsibility for maintaining group morale. Experience gained in this Unit indicates that all aspects of group living may contribute to this morale. They range in complexity from the basic elements of patient care such as personal hygiene, appearance, meals and housekeeping to the intricacies of meeting and understanding the emotional needs of the group members, staff as well as patients. As a teacher, she supervises, instructs and guides the clinical training of the students assigned by the nursing department. As a group leader she participates in both therapeutic and staff meetings. To fulfill these roles, she must have a basic knowledge of psychodynamics and sufficient personal integration to be able to empathize with those around her, while at the same time preserving her objectivity.

IN KEEPING with the diversified disorders of the patient, the approach to treatment is eclectic and multi-dimensional. For the most part the Unit utilizes the same diagnostic and therapeutic procedures that are available to in-patients. The exceptions are (1) patients who require dental or surgical care are referred to their private practitioner and (2) deep insulin coma therapy, high dosage drug therapy and psychosurgery are restricted to in-patients. After completion of the diagnostic studies, the findings are discussed in staff meetings at which time the individual treatment program is outlined. This variation has been introduced in order that what is known of the nature of the patient's disorder and the therapeutic aims formulated by the psychiatrist will be familiar to the individuals engaged in the treatment process.

Most of the technics are conventional and include modified total push, individual psychotherapy ranging from intensive brief technics to directive and supportive management, group psychotherapy, ataractic and stimulating drugs, electro-convulsive and electro-stimulative therapy, sub-coma insulin, and a wide selection of formalized activities therapy. The conditions under which these treatments are administered are also considered part of the therapeutic process. An excellent description of the historical evolution and current methods of study may be found in the Stanton and Schwartz monograph.[5]

The concept of milieu therapy includes both physical and social structure. The former has been described as comfortable and homelike. In a roughly analogous fashion, this principle is carried into the social structure. The group organization contains many of the elements of family life with its significant figures and its co-operative and competitive situations. However, this is a carefully planned and to some degree controlled family with a protective and supportive attitude towards its members. Its aim is to provide a safe atmosphere where attitudinal readjustment, growth and development are encouraged. The individual is given the opportunity to express his feelings (constructive and destructive) and to make his reassessments of reality in a setting that is both accepting and at the same time non-punitively corrective. The reduction of environmental stress appears to lessen individual anxiety and permit the healthier constructive aspects of the personality to function. As identification with the group develops, patterns of interaction between people become evident. These reactions often take the form of transference, not uncommonly multiple transference. Patients begin to act toward one another and toward members of the staff as they have toward significant figures in their past. An understand-

4. Greenblatt, M., York, R. H., Brown, E. L.: *From Custodial To Therapeutic Patient Care in Mental Hospitals.* Russell Sage Foundation, New York (1955).

5. Stanton, A. H. and Schwartz, M. S.: *The Mental Hospital,* Basic Books Inc., New York (1954).

ing of this process, together with the realization that it represents a distorted defense and the recognition that it is no longer necessary or effective, has been repeatedly observed as an important part of the therapeutic process. An allied phenomenon is the ability of patients to accept rejection or approval of certain aspects of their behavior more readily from the group than they are from authority figures. These and other group processes such as communication, misinterpretation, the achievement of personal recognition, status and prestige are discernible throughout the various communal activities including the diversional groups, *i.e.*, morning "coffee break," meals, conversation, dancing, games, parties, etc.

DURING the two-year period ending April 4, 1957, sixty-eight patients were admitted, thirty-four of whom were referred by private physicians. Six patients are still in the Unit, fifty were returned to the community and twelve were transferred to in-patient service. Four patients failed to sustain a satisfactory adjustment and were returned to the hospital. Of these, one was re-admitted for a short period and discharged. Including this patient, forty-seven or 76 per cent of the total treatment group are considered to have achieved significant improvement as a result of Day Unit care. The improvement rate, according to diagnostic categories, is in keeping with the expected prognosis. Of the three affective disorders, all achieved remission—the median duration of hospitalization for a five-day week was five weeks. In the psychoneurotic group sixteen of the nineteen patients (89 per cent) were significantly improved. The median duration of hospitalization was 4½ weeks. In the schizophrenic group of nineteen patients, eleven or 69 per cent were significantly improved. The median duration of hospitalization was nine weeks. Personality disorders showed an initial improvement rate of 80 per cent. The improvement rate for involutional psychotic reactions was 75 per cent and for chronic brain syndromes 40 per cent. Of those patients who required transfer to the in-patient service, two were chronic neurologic disorders, five were seriously disturbed schizophrenics, two were chronic brain syndromes, two were suicidal involutional depressive reactions, and one was a personality disorder. The latter was transferred for administrative reasons.[6]

IN CONCLUSION, it appears evident from the experience gained in this Unit, supported by the above results, that the Psychiatric Day Hospital has both limitations and potentialities as an additional community mental health resource for referral by the general practitioner. Its limitations are those dictated by the selection of suitable patients and the difficulties that are encountered with effecting changes in psychogenic elements of the family constellation. This latter problem is open to study and may be more successfully resolved in the future. Primarily, this type of facility offers the advantage of intensive psychiatric treatment to a selective group of patients with a minimal disruption of the family life and consequently fewer problems in rehabilitation. Secondary gains include the opportunity for psychiatric training and research, reduction of operating costs, and the opportunity for closer liaison between the general practitioner and the psychiatric facility.

6. Tobin, J. M.: Preliminary Evaluation of The Day Unit—N. J. State Hospital, Trenton. April (1956). Not published.

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A Method for the Early Care of a Colostomy

The authors here describe a simple method of preventing colostomy wound infection.

Infection may occur in wounds made when a colonic stoma is formed, particularly when the colon must be decompressed as an emergent procedure. Such a technic includes the insertion of a catheter into the colon. The loop of colon may be divided or not, depending upon the situation present in the individual patient.

Chemotherapeutic drugs and antibiotic substances have made possible major advances in the control of such infection. The digestion of feces by enzymes has permitted further progress in this field.†

A direct correlation exists between the length of time during which fecal material is prevented from soiling such newly created wounds and the rate of infection of these wounds. A catheter colostomy helps to some extent in preventing contamination of the wound. An enzyme to keep the feces small in size or liquid (so that the material will pass through the catheter easily) will maintain the catheter in place. The longer the catheter remains in the colon, the less chance for infection of the wound to occur.

At the time of operation, a number 26 french catheter, with three additional holes made in it, is passed well into the proximal limb of the colostomy through a stab wound in the center of a purse-string of number 00 chromic catgut suture. The suture is tightened and tied. The suture line is reinforced by Lembert sutures of the same suture material. One suture passes through the wall of the catheter. The catheter is connected to a bottle by the side of the bed.

Starting on the day after operation, 0.13 Gram of crystalline papain§ dissolved in 300 cubic centimeters of a warm, aqueous solution of zephiran chloride, 1 to 5,000, is injected slowly through the catheter every 12 hours until the catheter is sloughed out of the colon. The catheter is occluded for about two hours to permit digestion to take place and then is opened. The catheter is irrigated gently with water every two hours between injections of the enzyme to keep the lumen patent. Since feces do not soil the wound until the fourth or seventh day, infection of the wound is minimal or absent, and clean, strong wounds which heal rapidly result.

Ten patients have been treated in this manner. Eight had wounds which healed rapidly without infection. Two patients died in five days of advanced carcinoma but the wounds were clean at that time.

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† Godfrey, G. C. and Miller, J. M.: U. S. Armed Forces Med. J. 8:1131 (August) 1957.

§ The crystalline papain was supplied by Winthrop-Stearns, Incorporated, New York City, New York.

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Historical Article • • •

FRED B. ROGERS, M.D.*

Trenton

Dr. Nicholas Belleville (1753-1831): Aristocratic Physician**

Even without wonder drugs and modern surgery, a doctor could establish a reputation for effective healing of the sick. What he lacked in science, he had to make up in art: the art of caring for the sick by really caring about them. Here is a pleasant vignette of one such practitioner.

ALL too often in history, unsavory and violent people claim the attention of scholars. Respectable and productive folk, by contrast, are often taken for granted and so are more likely to become victims of "the iniquity of oblivion," to use Sir Thomas Browne's phrase.

This is an account of the life and work of a dedicated and colorful man, Dr. Nicholas Belleville, aristocratic physician at Trenton, N. J., over a century ago. An upright citizen of his adopted country, Revolutionary soldier, skilled medical practitioner and teacher, friend and associate of eminent men of his time, his memory is worthy of recall. His friendship with Alexander Hamilton is also of timely interest. Through facts assembled from various sources, we can reconstruct much of the man and the times in which he lived.

Nicholas Jacques Emanuel de Belleville was born in Metz, France, in 1753. Following an apprenticeship to his father, who was surgeon at the military hospital in Metz, he continued his medical studies in Paris, being one of twelve students to receive honors in his medical course of studies. A student of Dr. Belleville later wrote: "After seven years' study and practice in the schools and hospitals of that great city, where he enjoyed the most ample opportunities of acquiring professional skill, he received the diplomas of the school, accompanied with testimonials of the respect and esteem of his professors, which were long after recurred to with just pride and gratification." As a medical student in Paris, when Louis XVI came to the throne, Belleville often told of hearing the people shout (in allusion to the promises of Henry IV that every peasant might have a chicken for his pot-pie), "Poule-au-pot! Poule-au-pot!"

In the spring of 1777, Dr. Belleville met Count Casimir Pulaski, who had taken refuge in Italy after his ill-fated attempt to restore Polish liberty. The Count was preparing to leave for America and persuaded the 24-year old physician to accompany him on this venture. They left Nantes on June 9, 1777.

The crossing was a rough one. In advanced age, Dr. Belleville still recalled that he "was so d - - d sick, that he prayed that they might all go to the bottom together." The vessel in which he sailed was a sloop-of-war, mounting fourteen guns, and carrying a crew of 105

The author wishes to acknowledge the assistance of Mr. Francis Shippen MacIlvaine of Summit, N. J., great-great grandson of Dr. Belleville.

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men. She also had on board sixteen hundred stands of arms for the American revolutionists. On July 22, they arrived at Salem, Massachusetts, and from there proceeded to Boston on military matters. Dr. Belleville promptly received a commission in the American army, and, in the capacity of surgeon, travelled with Pulaski as the Count recruited additional men for his legion, which had been authorized by the Continental Congress.

WHILE camped at Trenton, New Jersey, in 1777, Belleville met Dr. William Bryant, an elderly physician of the town, who treated him cordially and encouraged him to establish himself in practice there. Belleville, however, left with Pulaski on the latter's to-be fatal Southern campaign. In the field Belleville received an urgent request from Dr. Bryant to return to Trenton as a medical practitioner. The military surgeon showed the old doctor's letter to the Count, who generously told him that it was not his wish to stand in the way of his advancement. Belleville chose to leave the army, and in the Fall of 1778 took residence in Trenton, where he remained for the rest of his life.

Dr. Belleville soon became eminent as a practitioner, teacher, and medical society leader. Not long after settling at Trenton, he received an invitation to join the distinguished Dr. John Jones for practice in Philadelphia—an offer declined because of his recent marriage to a Trentonian. Numerous tributes from his patients, students and colleagues attest to his skill—and social charm. He had an extensive practice in Trenton and for many miles around. A student described him as "always travelling on horseback at a high rate of speed. It took both good horses and good riders to keep up with him . . . His manner was quick and peremptory—occasionally to the hither verge of rudeness—but it was manner only, his nature being kindly to a degree." Personally known to medical leaders in Philadelphia, Dr. Belleville was called in consultation with Doctors Bond, Cadwallader, Jones, Rush, Physick, Coxe,§ Chapman and others.

In a letter dated September 3, 1793, written during the devastating yellow fever epidemic in Philadelphia, Benjamin Rush first announced his mercurial purge to Nicholas Belleville. This drastic remedy, along with copious bloodletting, Rush came to regard as a specific for yellow fever. The notorious "Rush's ten-and-ten" ("thunderbolt") incorporated jalap—in equal 10 grain doses, "to carry the calomel through the bowels." (Rush's antagonist William Cobbett wryly observed that this cure was "one of those great discoveries which have contributed to the depopulation of the earth.") Reading of Belleville's respect for the healing power of nature makes one wonder how often he really heeded Rush's advice in this treatment.

DURING the outbreaks of yellow fever in 1793 and 1798, the national offices of the Government were moved temporarily from Philadelphia to Trenton. During these periods, Alexander Hamilton and his wife, the former Elizabeth (Betsy) Schuyler — members of whose family were Trenton residents, were often in the company of Dr. Belleville. Their eldest son, Philip (who was later killed, as his father was to be, in a duel), had enrolled in 1791 at a boarding school in Trenton kept by the Rev. William Frazer of St. Michael's Episcopal Church. On one occasion, we learn from a later report, Alexander Hamilton "was under the impression that he had the fever, and sent in a great hurry for Belleville. On the doctor's arrival, he found the Secretary in a highly nervous state . . . Belleville knew that he must prove to him that he had none of the symptoms, and asked for his watch. They both noted accurately his pulse, which was 74. 'Recollect that, Mr. Hamilton,' he said. 'Have you a thermometer?' was the next question. One was brought, the bulb put under his tongue a few minutes; when he was told to mark the point at which it stood—98 degrees. 'And now will you be so good as to have brought a small looking glass, so that we may observe your tongue,' was the next request.

§Little of Belleville's correspondence survives today. One undated letter—a reply to an inquiry from Dr. John Redman Coxe concerning "the vaccination of Mr. Cottineau's son"—is in the *Gilbert Collection of Manuscript Letters* (vol. 4, p. 233) at the College of Physicians of Philadelphia.

When this was produced, he wished the patient to look at his own tongue, and then at another's, a well person at the bedside, which he did, and said he could see no difference. 'Now,' said Belleville, 'Mr. Secretary Hamilton, you are a man who, in important cases, never forms an opinion without what you deem a sufficient reason—you must know by some of its logical antecedents that the thing is so. As we know diseases by their symptoms only, as you have a natural pulse, natural heat of the body, a natural tongue, and a clear head—all evidences of health, how . . . can I say that you have the yellow fever when you have none of its symptoms?' The Secretary was convinced, and by the only method that could perhaps have decided him in his terribly excited state."

Dr. Belleville met General George Washington while serving in the Revolutionary War. Writing of Dr. Belleville's admirable character at the time of his death, a former pupil, Dr. Francis A. Ewing of Trenton, noted: "He had a deep veneration for whatever was excellent in morals, exalted in intellect and amiable in virtue; and wherever these traits were exhibited, he paid an ardent and willing tribute of admiration. Under the influence of such sentiments, the character of Washington, with whom he was acquainted personally, was one on which he loved to expatiate." It is probable that Dr. Belleville was among those who greeted Washington on April 21, 1879 upon his triumphal reception at the bridge in Trenton on his way to be inaugurated first President of the United States.

ANOTHER famous man whom Belleville befriended, and also attended professionally, was Joseph Bonaparte, Count de Survilliers, King of Spain and Naples. He was eldest brother of Napoleon. Joseph fled from Europe to the United States in 1815 and purchased an estate, "Point Breeze," at Bordentown, New Jersey. He settled there with his circle of friends and family, living regally and entertaining freely at his mansion. In his entourage were his secretary, Louis Malliard, a former captain in Napoleon's army; the Count's beautiful daughter, Princess Zenaide; and his nephew, Prince Lucien Murat, a particularly colorful personality. (Bonaparte Park still exists at Bordentown—home of a church order—and the lonely grave of the Count's American daughter, "Pauline," may be seen today in St. Michael's churchyard at Trenton—"escaped from the World's unpitying malevolence.")



Residence of Joseph Buonaparte, Bordentown.

Figure 1. Residence of Joseph Bonaparte at Bordentown, N. J.

Dr. Belleville served as regularly-appointed physician to Joseph Bonaparte during the Count's stay in the United States. The doctor's stated salary was five hundred dollars a year—a fortune for those times. Descendants still exhibit a handsome chair given on one occasion by the grateful patient to his doctor. During his visit to the United States in 1825, Lafayette met Dr. Belleville at breakfast in Trenton on July 16, before visiting Joseph Bonaparte at Bordentown. An interesting anecdote survives from the period of Belleville's professional attendance upon Bonaparte. "After the doctor had been attending Joseph Bonaparte for some time, the Count's secretary called to know the amount of compensation due for professional services. The doctor asked the secretary if his attendance . . . had been satisfactory. 'Certainly, most certainly,' was the reply. 'Then,' said the doctor, 'I am sufficiently paid—that is sufficient compensation.' Although the secretary remonstrated, the doctor was determined. A few days after, the secretary returned with a check for six hundred dollars, and told the doctor they could not judge what would be a proper amount, but to look upon the check as something to be increased if not sufficient. The doctor said

in answer: 'Whatever the Count and he thought was entirely satisfactory to him.'"

"Gentlemen," said Belleville, when relating this to his students, "If I had made out a regular professional bill, it could not have been more than seventy or eighty dollars; but you must recollect that I was dealing with a king, and when you have a king for a patient, treat him as a king, and not as a common man—with regard to money."

Again on February 5, 1831, the Female Benevolent Society of Trenton acknowledged an opulent gift of fifty dollars "from the Count de Survilliers, by Dr. Belleville."

Other French exiles were known to Dr. Belleville, among them General Jean Victor Moreau, the military leader who was banished by Napoleon for a supposed part in a plot against the life of the First Consul, under whom he had served earlier with distinction. This refugee lived at "Summerseat," former home of Robert Morris, "Financier of the Revolution," at Morrisville, Pennsylvania. This home, still standing, had served briefly as Washington's Headquarters in December, 1776. George Clymer, who, like Morris, signed both the Declaration of Independence and Federal Constitution, also lived for some time at "Summerseat." Across the Delaware River, in the southern part of Trenton, there was also a settlement of wealthy French exiles from the rebellion in Haiti. These were among the numerous fashionable folk with whom Nicholas Belleville mingled as physician and friend.

As was the custom of the time, Dr. Belleville served as preceptor to numerous medical apprentices during many years of practice. His widespread reputation brought him students from all parts of the Delaware Valley. Several tributes from former pupils survive to tell of his skill and kindness. A partial list of his student-physicians will attest to his popularity as a teacher: Drs. James T. Clarke (who became the husband of Belleville's daughter, Mary), James B. Coleman, Francis A. Ewing, George Holcomb, and Thomas L. Woodruff of Trenton; William Geary of Flemington; John H. Phillips of Pennington; Henry Holcombe of Allentown; William B. Ewing of Greenwich, John Lilly of Lambertville, William D. McKissack of Millstone, and others. The high positions which these physicians subsequently attained in the medical profession of their day speaks well for their instruction while with Dr. Belleville. The *Obituary* written by his pupil, Dr. Francis A. Ewing, already cited, tells of his skill as a teacher, and is one of the finest tributes to a physician I have ever read:

> "Dr. Belleville possessed, in a remarkable degree, those qualities which make up the character of an accomplished physician. He was cautious and minute in investigation—keen in observing—careful and deliberate in deciding—accurate in judgment—prompt and efficient in the administration of remedies—candid and conscientious in advising—kind and soothing in deportment. His comprehensive mind was stored with the learning and wisdom of the many great men who have adorned . . . the profession of medicine . . . The confidence reposed in him, he considered a sacred trust. Every case, however, familiar to his experience, received its due investigation . . . Conduct so honorable, a discharge of duty so conscientious, could not fail to be rewarded with the respect of all . . . He (also had) a remarkable relish for books (of which he possessed a very extensive and valuable collection) and to this unchanged habit of reading and reflecting, is to be attributed that vigor of mind which never deserted him.
>
> "Among the many who pursued under his care the study of medicine, there is . . . not one who will learn of his death without deep emotion. Especially those, who were with him in later years, and to whom his time was more completely devoted . . . They can never forget his earnest fidelity in imparting instruction—his parental solicitude in giving counsel—his fervent wishes for their prosperity—and the solemn and affectionate manner in which his parting blessing was always pronounced, when any of them left him."

Of the early physicians of New Jersey, none was more highly esteemed than Nicholas Belleville. He became a member of The Medical Society of New Jersey at its annual meeting at New Brunswick on June 13, 1809. Two years later he was one of three examiners appointed for a two-year period to examine medical candidates from the Middle District of New Jersey (four counties). In 1812, he became one of three chief examiners for the entire state. Two years later, Dr. Belleville was among seven physicians named to plan the incorporation of a separate medical so-

ciety for each county in the state. In 1815, Belleville was elected Vice-President of The Medical Society of New Jersey for the ensuing year. On November 9, 1819, Belleville and five other physicians formed a District Medical Society for Hunterdon County,† of which he became the first president in February, 1820. (Mercer County was subsequently formed from Hunterdon and Burlington Counties in 1838). That Belleville continued active in medical affairs until late in life is evident from minutes recorded at Trenton on November 12, 1822—"Dr. Bellevilie, formerly President of the District Society of Hunterdon, favored the Society with his attendance."

A portrait of Dr. Belleville, possibly painted by one of his medical students, is now owned by his great-great grandson. It depicts the doctor in his later years. A volume on the table, "Desault's Surgery," dates the portrait after 1814—the year this tome appeared in English translation. The erect posture, lean features and alert mien are consistent with contemporary records. His appearance and manner also survive in accounts by several contemporaries: "Six feet and upwards tall, very slender, throughout life he seemed like one who had a frail constitution, yet few men lived so many years with better general health."

A GROUP of lawyers, drinking and gormandizing on one occasion in Trenton between court sessions, being "familiar with the doctor, used to joke him on his leanness, as well as his abstemious and careful habits. One of the leaders of this reckless set, not having seen Belleville for some time, met him one day in the street, and expressed surprise at finding the lean Frenchman, as he called him, still alive. 'Sir,' said the Doctor, irritated, 'I will live to stamp on the graves of every single one of your d - - d set.' He afterwards said that he could do it, for the very last of the fourteen had died some years before, and here was he, the lean Frenchman, alive and well, when all the gluttons were gone."

On the subject of overeating, Belleville added: "Gentlemen, in France, when I was



Figure 2. Portrait of Dr. Belleville—artist unknown.

there, men ate to live, but in this country, it seems to me people live to eat.‡ In France, a plate, rubbed with an onion, seasoned and gave relish to the meal. With a small piece of meat once a week, the people were satisfied. Here every man's market basket must hold, daily, meat enough for a regiment."

Another contemporary reported: "He was a cautious, philosophic physician. His advice to his students—of which he had a number in his time—some quite celebrated in their day—was always practical common sense, such as this:

"When you are called to a sick man be sure you know what the matter is—if you do not know, nature can do a great deal better than you can guess. If you have a broken leg to treat, be very careful—be very particular. If you set it crooked, and the man goes limping through life, he will curse you every time he sees you—but if he is taken down with a fever, and dies, the grave will cover up all your mistakes, and ten chances to one you get great credit for skill and attention. The advantage that the practice of medicine has over surgery is, that if you do not know what

†Trenton was then in Hunterdon County. There *was* no Mercer County until 1838.—Ed.

‡The phrase does not seem to have originated with Dr. Belleville. In his *New Dictionary of Quotations* (Knopf 1952) Mencken traces this to an English, not a French proverb, known at least as early as 1410. However, Cicero in *Ad Herennium* wrote "Edere oportet ut vivas, none vivere ut edas" which means precisely the same thing.—*Editor.*

the matter is, you can call it occult, and get off with credit, but as surgery is demonstrable, they hold you to the proof."

Asked on one occasion about the varying quality of physicians, Belleville stated: "If you get one *good* doctor, you get one *good* thing, but if you get one *bad* doctor, you get one *bad* thing. If you have a lawsuit, you get one bad lawyer, you lose your suit—you can appeal; but if you have one bad doctor, and he kills you, then there be no appeal."

Speaking of patients, he said: "If you have patients of good sense, and they need no medicine, only advice, explain the matter to them, but if you are treating d - - d fools, give them bread pills."

Numerous tales survive depicting Dr. Belleville's ready wit and droll sense of humor. A contemporary recalled, "He was not eminently pious . . . The fact of the matter is, that many of his pithy sayings were dependent for their point upon a spice of profanity." A typical anecdote will suffice: "A young man called to have a tooth extracted; from some cause, whether accident or design, he bit the doctor's thumb and fore-finger. Finding himself in danger from the doctor's other hand, he was obliged to hold on with his teeth till he got in a situation to make good his escape, during which time the doctor was talking to him pretty freely. After his escape, he thought it best to keep out of the doctor's way, but, on an occasion, the doctor coming suddenly into the main road, saw just in advance of him this same young man, mounted on horseback too . . . The doctor let his horse out, and with many gestures, as if preparing to shoot, ran the young gent and his horse to Trenton, to the doctor's very great satisfaction . . . and to . . . the amusement of all who saw it, who declared they never saw a race better contested."

"Extensive rural practice, horseback exposure, bad roads, and loss of sleep . . . had to be systematically guarded against by the most careful living—dress, diet, and rest. When he was cold and weary, he asked for coffee, not spirits, and after losing sleep made up the loss as soon as possible—by regulating his life after the fashion he lived in good health to an advanced age."

Nicholas Belleville's wife, Ann Brittain, came from an influential Trenton family who owned the land where the New Jersey State Capitol now stands.† Of this union came two daughters, Mary, who became the wife of Dr. James T. Clarke of Trenton, and Sarah, who married Rev. Andrew Hunter, Professor of Mathematics and Astronomy at Princeton College. Dr. Belleville's wife, a pious and exemplary woman, was a communicant of the First Presbyterian Church in Trenton. The Doctor was a pew-holder and occasional attendant. It is recorded, however, that "he was too fond of his elegant edition of Voltaire to relish the Gospel." He was an active member of Trenton Masonic Lodge No. 5, chartered in 1787 and still flourishing.

"THE influenza was prevailing at the time of his death. He had it, and was conscious of his approaching end. In the evening, his nurse took the candle, and was about to leave the room for a moment (when) he said to her sternly, 'Put that candle down! You don't wish to let me die in the dark, do you?' She thought but little of it at the moment, got another candle, and . . . discovered that he was dead."

Dr. Francis A. Ewing, the devoted pupil who composed an obituary for the *New Jersey State Gazette* of December 24, 1831, also furnished the inscription for his mentor's grave. On a tablet in the First Presbyterian Churchyard at Trenton, one can read this epitaph:

"This stone covers the remains of Dr. Nicholas Belleville. Born and educated in France; for fifty-four years an inhabitant of this city. A patriot warmly attached to the

†It would be interesting to report that the Essex County town of Belleville named itself for this doctor. Belleville was, at first, the "Second River" section of Newark, then part of Bloomfield. Eight years after the death of Dr. Nicholas Belleville, this section became an independent town. Because of its site, overlooking the then beautiful Passaic River, the town fathers called their new community, "beautiful town: belle ville." The Trenton Belleville family were, presumably, named for some "belle ville" in France—*Editor.*

principles of liberty; a physician eminently learned and successful; a man of scrupulous and unblemished integrity. On the 17th of December 1831, at the age of seventy-nine years, he closed a life of honor and usefulness; by all respected, esteemed, lamented."

2200 Hamilton Avenue

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Psychiatric Care for Children

Announcement has been made of the opening of a small in-patient service for emotionally disturbed children at the Memorial Hospital in Chapel Hill, North Carolina. This is under the auspices of the University of North Carolina. Inquiries should be addressed to Admitting Officer, Psychiatric Center, Memorial Hospital, Chapel Hill, North Carolina.

Arthritis Selective

Divorced women suffer most from arthritis. Although it long has been known that arthritis strikes more women than men, a new study shows that prevalence of the disease increases in women after they get married and is even higher for divorced women. These findings were based on a study of 80,000 persons in the Arsenal Health District of Pittsburgh.—Dr. Sidney Cobb, University of Pittsburgh.

Ten Per Cent Like the A.M.A. as It Is

Five hundred physicians were given a chance to put themselves in Dave Allman's shoes and asked to suggest the changes they would make in the A.M.A. Questioned in a nationwide survey authorized by AMA, they most often call for closer ties with the individual physician and for further improvements in public relations. Thus, one doctor in five thinks AMA should get closer to individual doctors, perhaps pool their ideas on important subjects to get a more accurate indication of their feelings. A smaller proportion think there should be a greater representation of young doctors within the Association.

Improved public relations and public information was the second important Association change suggested. Concentration upon these areas was called for by 14 per cent of the doctors.

Nine per cent cite social security or pensions for doctors. One out of twenty requests liberalized hospital affiliation requirements and about the same number suggest higher standards for practice. About five per cent say improvements ought to be made in the *Journal* of the A.M.A.

Smaller percentages say opposition to government medicine should be strengthened by the Association and 2 per cent call for elimination of fee-splitting. Increased post-graduate training is also suggested by 2 per cent.

About one doctor in ten says he thinks the Association needs no improvements — that it's satisfactory as it is.

State Activities • • •

Trustees' Meeting December 15, 1957

At its December 15, 1957 meeting, the Board of Trustees:

—Received a report from Dr. Kump that he had presented this Society's check for $10,000 to the American Medical Education Fund.

—Renewed Mr. Nevin's contract as Executive Officer for a three-year period ending in 1961.

—Authorized all members of the Medicare Committee to go to Washington in June to renegotiate the contract.

—Adopted the report of the committee on the Medicare Conference. See below.

—Voted to oppose the Forand Bill (HR 9467) which would provide free hospitalization of the aged under social security.

—Endorsed the report of the special committee for the study of the policies of the Medical-Surgical Plan. See page 79 this JOURNAL.

—Authorized the usual annual contribution of $25 to the National Society for Medical Research.

—Voted to disapprove of county society collaboration in the year-round program for diabetes detection on the grounds that "diabetes is a non-communicable disease adequately handled by private physicians, and is not the responsibility of the State Department of Health as a continuing program."

—Referred to the Subcommittee on Public Health the question of whether county medical societies should cooperate with the New Jersey Consultation Service for Convulsive Disorders.

—Asked Dr. Allman to represent our Society at the AMA Congress on Medical Education and Licensure in Chicago in February.

—Invited the American Medical Association to meet in Atlantic City in 1963.

—Authorized a fee of $150 to our counsel, Mr. Backes, for "extraordinary service" in representing The Medical Society of New Jersey at several hearings before the Trenton Zoning Board.

—Authorized the signing of supplementary agreements concerning MSA expense rates.

Conference on Medicare

December 6, 1957

L. SAMUEL SICA, M.D., Trenton

The Conference on Medicare was sponsored by the American Medical Association Board of Trustees' Task Force on Dependent Medical Care. Dr. Edward S. Hamilton, Chairman of the A.M.A. Task Force, presided. More than one hundred participants registered from forty-four state associations.

Dr. Hugh S. Hussey, Jr., Chairman of the Special Committee of the A.M.A. Task Force, presented some of the many problems now being dealt with. Among the questions under consideration are: "Should this program be extended to include retarded personnel; to include other dependents such as parents and parents-in-law; to include parents of deceased personnel? Should it be enlarged to include outpatient care; dental care; psychiatric care; medical emergencies; and care of *some* chronic diseases?" Dr. Hussey indicated that answers would be worked out on the basis of adherence to standards of sound medical practice and sound economies.

Dr. Hussey was followed by Colonel Earl C. Lowry, M.C., and Lt. Colonel Ralph J. Richards, Jr., M.S.C.

Colonel Lowry announced that a new Manual for Physicians, enlarged and revised, will be made available to state societies. He hoped that in its revised form it would satisfactorily deal with many points that proved troublesome hitherto in the matter of procedures and fees.

He touched on the wide range of administrative costs. Average administrative costs

equal 3.5 per cent of totals paid out. The actual dollar cost for processing single physician claims ranges from one dollar to $11.42 per claim. It is the opinion of the office of dependent medical care that the administrative cost per claim should not exceed $3.00. Colonel Lowry reminded his hearers that all contracts were due to expire on June 30, 1958, but they have been extended through 1958, to be renewed at staggered dates. He informed the conferees that at least sixty days before the date set for renegotiation of contract, advance materials relevant to the new contract would be supplied to state associations. He said (1) the basic contract will be restated, (2) revisions arising from experience will be included, (3) revisions will be made to eliminate inconsistencies, and (4) audit requirements will be eased. As far as he could see there would be no significant additions or deletions to the present contract.

Colonel Richards brought out that although some states have not agreed to accept the plan, doctors in those states who give service must fill out the required forms and submit them. Such submission obliges the doctor to accept the Medicare fee. Some states are pressing for the operation of the program on an indemnity basis. The Medicare program was conceived and established on a service basis. It can be changed only through the action of the Defense Department and Congress.

Some speakers from the floor pressed the point that the general practitioner should *not* receive the same fee for service rendered as the specialist. In answer the conferees were reminded that fees listed in the schedule of payments are maximum fees and that if the practitioner's regular fee is less than the maximum, he should not bill for the maximum.

A detailed report of the entire conference will be made available to state associations. That report should contain much information of value to our committee in its concerns.

M - S Plan Policies

Report to the Board of Trustees

From the Special Committee on the Study of Medical-Surgical Plan Policies

NICHOLAS E. MARCHIONE, M.D., Chairman

In conformity with the action of the House of Delegates, in April 1957, this special committee was appointed by the President to study the policies of the Medical-Surgical Plan of New Jersey. From an analysis of the resolution which formed the basis for the action of the House of Delegates and from the implications contained in the action establishing this committee, it was apparent that also imposed was an obligation to investigate and weigh expressions of dissatisfaction with Plan policies or practices originating with members of The Medical Society of New Jersey. As a means of insuring that the Committee might have full appreciation of members' attitudes of criticism or disapproval of the Plan, a request was published in the *Membership News Letter** urging all members to submit complaints, criticisms, and constructive suggestions to the committee. In all, four letters were received in response to this invitation.

BACKGROUND

No evaluation of the policies of the Medical-Surgical Plan of New Jersey can begin without recalling the fundamental purpose which underlay and underlies the Medical-Surgical Plan. Medical-Surgical Plan was established by The Medical Society of New Jersey as a means of utilizing the insurance principle to enable individuals and families in middle and low income groups, as independent and responsible agents, to provide and pay for medical and/or surgical care and treatment made necessary by catastrophic illness. It was conceived and intended to encourage such citizens to take care of themselves without benefit of state or federal largess, and thus to keep them and the practice of medicine free from government restraint or control, developing as a concomitant to government support.

The Medical Society of New Jersey in June 1938 declared it to be one of its objectives "to make available to every man, woman, and child in New Jersey adequate personal and sympathetic medical care, preventive and curative, at the lowest cost compatible with efficient service." Participating physicians—in number now equivalent to approximately

* August-September, 1957 issue.

eighty per cent of those practicing medicine and surgery in New Jersey—have agreed to accept as full payment the compensation made to them by the Plan for specified eligible services rendered to eligible Plan subscribers whose income is less than a certain agreed upon maximum. At the present time that maximum is $5,000 for an individual subscriber, and $7,500 for subscriber and spouse. In instances where income exceeds these limits, the participating physician is entitled to submit a reasonable bill for the difference between Plan payment and his regular professional fee for the services rendered. In all other instances the participating physician is bound by contractual agreement to accept the Plan's payment as payment in full. The difference between his regular fee and that which he accepts from the Plan is in effect his contribution to the service and welfare of people in middle and low income groups, and to their continuing freedom and independence, and the continuing freedom and independence of the practice of medicine.

THE SERVICE PLAN FEATURE

Operation of the Plan within the limitations of income and expenditure imposed by its nature and purpose has, as a matter of course, produced elements of dissatisfaction and areas of discontent. It is to the credit of the Board of Trustees of Medical-Surgical Plan that so much of satisfactory adjustment has been accomplished in the brief but flourishing life of the Plan—that so many subscribers and participating physicians are pleased and so few displeased. The Plan offers the assurance that efforts are constantly being made to pay all physicians maximum benefits for services rendered, within the financial structure of the Plan.

One of the best selling points for Medical-Surgical Plan, the feature which obviously proves most attractive and compelling to the majority of subscribers, is that it is a *service* and not an indemnity type of coverage. Consequently the outstanding source of dissatisfaction to subscribers is the discovery that, under certain circumstances, the Plan's payments assume the character of indemnity payments. This is so where non-participating physicians render the eligible services or where participating physicians submit supplementary bills either because the subscriber's income exceeds the acceptable maximum set in the contract, or because extraordinary services, not covered in the Plan's schedule, have been supplied. Subscriber dissatisfaction in perhaps eighty to ninety per cent of the complaints submitted is attributable to this area of concern.

Just as the subscriber is chagrined if he thinks he is being unfairly made to pay too much, so the physician bridles if he thinks he is being asked to accept too little. In most instances full explanation of the terms of the contract—as regards both subscriber and physician—is sufficient to bring about understanding if not, in every case, complete satisfaction.

Many non-participating physicians have made known their dissatisfaction with the current policy of Medical-Surgical Plan of making payment directly to subscribers for eligible services rendered by non-participating physicians. The Plan pays participating physicians directly. It is alleged by non-participating physicians that payment to subscribers for the services which they render is an inequity which should be eliminated; and payment for eligible services rendered should be made directly to non-participating, as well as to participating, physicians.

The Plan points out that it has contractual agreements with participating physicians, on the one hand, and with subscribers, on the other. Therefore direct payment to participating physicians is in fulfillment of a contractual obligation. No such contractual obligation exists with reference to non-participating physicians. In connection with non-participating physicians, in most instances Plan payment assumes an indemnity character, and the amount made available under the Plan's schedule of benefits must be added to by the subscriber to effect payment in full for the services of the non-participating physician. Hence in fulfillment of its contract obligations with the subscriber, the Plan pays the subscriber, who, in turn—in fulfillment of *his* contractual agreements with the non-participating physician—pays him. In short, direct payment to participating physicians is a benefit of membership in the Plan.

COMPOSITION OF THE BOARD

Another frequent complaint against the Plan is the allegation that the Board of Trustees of Medical-Surgical Plan is made up of a disproportionate number of surgeons, and that therefore physicians in other fields are not adequately represented. In answer to this, spokesmen for the Plan point out that nominations to the Board are made upon the individual's status as a physician—and not as a specialized

practitioner—who is competent and willing to sacrifice the time and effort necessary to guide the Plan in its formulation of policy and procedures, and to supervise its general operations. All nominations are subject to the approval of the House of Delegates of The Medical Society of New Jersey. At the present time, seven of the nineteen-man Board are physicians who limit their practice exclusively to surgery, seven are physicians who represent other phases of professional activity, and five are laymen.

From time to time other criticisms are leveled at the Plan. It is charged that the schedule of benefits is neither realistic nor equitable in compensating for medical services as compared with major surgical services. Some times complaints are received that Plan payments are not promptly made. The Plan is sensitive to both these complaints. Efforts are being made to arrive at a means of acceptable balance; and new and improved processing methods are constantly being adopted to increase the efficiency and promptness of the handling of claims.

CONCLUSIONS

It is inevitable that a program of such extensiveness and magnitude as the Medical-Surgical Plan—dynamically evolving as it is—should be beset by complexities and difficulties that produce some discontent and dissatisfaction. The discontent—as far as your committee could discern—is by no means "widespread among our members" as the House resolution alleges. By and large, the policies, procedures, and benefits of Medical-Surgical Plan are a source of real satisfaction to the majority of participating physicans. Non-participating physicians are uneasily critical of alleged discriminations that in large part are attributable to the status in relation to the Plan which, by their own choice, they prefer to maintain. By becoming participating physicians they could enjoy the direct payment of benefits which seems to be the accommodation which principally they seek.

Your committee is of the opinion that lack of understanding—on the part of subscribers and physicians alike—concerning the policies and procedures of Medical-Surgical Plan, is the basis for most of the complaints that arise.

RECOMMENDATIONS

Therefore your committee recommends:

(1) That sustained and comprehensive educational efforts be directed to both subscribers and physicians, to inform them adequately of all aspects of the Plan's operations.

(2) To this end, in connection with bringing information to members of The Medical Society of New Jersey, it is recommended that this, or a similar committee, be continued by the Board of Trustees of The Medical Society of New Jersey, to serve as a clearinghouse for the dissemination of information. It would be a function of this committee to receive written questions and complaints concerning the Plan from our members, and to supply authoritative answers and responses after investigation and consultation. All information provided by such committee should be published for the enlightenment of the entire membership through a department established for that purpose in the *Membership News Letter* and other publications of the Society.

(3) The Medical-Surgical Plan committees of all component societies should be reactivated, to serve—at county level—in supplying information about the Plan and in reflecting to the state committee the attitudes and reactions of member-physicians. As necessary, the county committees could coordinate their efforts with those of the state committee and assist in its efforts to appreciate all points of view, and to provide a complete informational service to both Medical-Surgical Plan and the members of The Medical Society of New Jersey.

This report would not be complete without my expressing profound appreciation to the members of my committee: Doctors Edward G. Bourns, R. J. Cottone, Charles L. Cunniff, Frederick W. Durham, and Morton F. Trippe. I also want to record the committee's appreciation of the contribution made to its deliberations by Doctors Harry N. Comando and Rudolph C. Schretzmann, members of the Boards of Trustees of the Medical-Surgical Plan, who served as consultants to the committee, and who stand ready, as do other members of the Board of Trustees of Medical-Surgical Plan, to meet with any group of the Society's membership for purpose of discussing the Plan.

AMA Interim Meeting

Our Society's AMA delegates* reported the high-lights of the Philadelphia (Interim) meeting of the AMA as follows:

Your delegates commend our speaker and vice-speaker for continued efforts to streamline the work of the House. Elimination of roll call, simplification of voting procedures, tables for all delegates, provision of mimeographed resolutions before introduction, and the reports of Reference Committees also mimeographed, together with separate slotted folders for filing, not only add to convenience but afford the delegates an opportunity for better consideration and study of the material.

FREE CHOICE OF PHYSICIANS

Two resolutions dealing with this topic were considered—one in relation to the policy of the United Mine Workers of America Welfare Fund in its attitude toward utilization of physicians and hospitals, and the other in relation to contract practice. On the first item the House condemned this policy as "tending to lower the quality and availability of medical care to the beneficiaries of the Fund and called for a broad educational policy to acquaint the public as to the benefits to be derived from the free choice of physicians and hospitals."

FLUORIDATION

This problem was probably the most provocative of the sessions. The position taken by the House is "That fluoridation of public water supplies is a safe and practical method of reducing the incidence of dental caries in childhood."

THE HELLER REPORT

Last June a committee was appointed to study and report on this survey of the business organization of the association. This committee made twelve recommendations which were referred to the Council to be acted upon at the Annual Meeting. Among the recommendations are:

1. Combining the office of Secretary and Treasurer, to be selected by the Board of Trustees from one of its members.
2. Discontinuance of the offices of General Manager and Assistant Secretary and substitution of an Executive Vice-President and an Assistant Executive Vice-President.

*Report prepared by Drs. Blaisdell, Costello, Crowe, Hurff, Sica and Weigel.

MEDICARE

Disapproved a resolution asking for legal action to compel the Department of Defense to make Medicare an indemnity plan. Suggested that in re-negotiations each state procure regulations to enable its plan to operate on an indemnity basis if it so desires.

PUBLIC ASSISTANCE

Adopted a resolution providing that payment for medical services rendered to public assistance recipients be paid directly to the physician rendering that service.

GROUP PRACTICE

Adopted a resolution in reference to group practice saying that "It is within the limits of ethical practice for physicians to join in partnerships, associations, or other lawful groups, providing the ownership and management thereof remains in the hands of licensed physicians."

FORAND BILL

Commendation was given to the Task Force for the positive action already taken to defeat this measure. Especial mention was made of the impact already made on the profession and the public by President Allman's many discussions alerting all to the dangers of this legislation.

CIVIL AERONAUTICS

A resolution decrying the inadequate facilities of the Medical Department of this group was presented, and it was strongly recommended "that a completely adequate and competent medical department be established in the C.A.A. directly responsible to the administrator of the C.A.A. and an adequate budget be provided."

PRESIDENTIAL ADDRESS

In reports of officers the Reference Committee laid especial emphasis on the significance of President Allman's address, citing its timeliness, forcefulness, and his demand for positive action. The enthusiastic reception given his address made our New Jersey Delegation proud and happy.

Proposed Revision of the Constitution

The following proposed revision of the Constitution was approved by the House of Delegates at the 1957 Annual Meeting and will be presented for final approval at the meeting in May, 1958. It is herewith published in full in compliance with the Constitutional provision to that effect.

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey".

ARTICLE II—PURPOSES

The purposes of this Society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance the art and science of medicine, elevate professional standards, safe-guard the interests of, and promote friendly relations among, members of the medical profession;

To promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey; and, in general,

To render the members of this Society most capable of serving mankind.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this Society shall be known, and referred to in the Constitution and Bylaws, as component societies. There shall be no more than one (1) component society in any county.

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 1—Composition

This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing, and Emeritus Members. Honorary Members may be elected, but they shall not be members of the corporate body.

Section 2—Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society.

Section 3—Officers

The Officers shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, a Secretary, a Treasurer, the elected members of the Board of Trustees, and the Judicial Councilors.

Section 4—Delegates

Delegates shall be chosen by and from the component societies, and shall be members of this Society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society's continuing in good standing in this Society.

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March thirty-first of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

(b) Reapportionment. In the event of geographic subdivision of any of the existing counties of New Jersey, and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided.

(c) Delinquency. In the event that a component society becomes delinquent to this Society, its entire delegation shall lose its status for the period of such delinquency.

(d) Vacancy. A vacancy shall exist in the delegation of any component society whenever one (1) of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two (2) consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

(e) Alternates. Each component society shall elect, at any meeting prior to March thirty-first of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate.

A regular delegate, if unable to attend a session of any meeting of the House of Delegates, may inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when registered and seated in the House of Delegates shall retain his seat during the remainder of the meeting.

Section 5—Members of Component Societies

All members of component societies in good standing are hereby constituted members of this Society and are entitled to full privileges.

Associate members of component societies in good standing are hereby constituted associate members of this Society, but they may not vote or hold office.

Section 6—Emeritus Members

Emeritus members shall be physicians who have been members in good standing of a component society for at least twenty (20) years, and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service. Nominations shall be submitted by the component societies, and emeritus membership shall be conferred by a majority vote of the House of Delegates. Emeritus members shall have all the privileges of membership except the right to vote and hold office, and their respective component societies shall not be assessed for such members provided they are carried as emeritus members in said component societies. Emeritus members shall not be included in the membership of a component society when computing the number of delegates to which such society is entitled.

Section 7—Honorary Members

Honorary members shall be physicians who have attained distinction within the medical profession; or persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trustees shall be officially transmitted to the component societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component societies shall be required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds (2/3) vote of the House of Delegates at the first session. Presentation of the honorary membership shall be made at the closing session of the House of Delegates. Honorary members shall not be members of the corporate body. At no time may the number of living honorary members exceed twenty-five (25).

ARTICLE V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates.

Section 2—Speaker

The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.

ARTICLE VI—BOARD OF TRUSTEES

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.

From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between

expiration of the second and commencement of the third term. The term of any Trustee commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.

At the first election of officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

ARTICLE VII—JUDICIAL COUNCILORS

The Judicial Councilors collectively shall comprise the Judicial Council which shall be the judicial body of this Society. The House of Delegates shall organize five (5) councilor districts within the State. It shall elect one (1) Judicial Councilor from among the membership of each of the five (5) districts.

ARTICLE VIII—MEETINGS

Section 1—Annual Meeting

This Society shall hold at least one (1) meeting annually. The time and place for such meetings shall be fixed by the House of Delegates. The Board of Trustees may change the time and place when necessary.

Section 2—General Session

During the annual meeting there shall be at least one (1) general session that shall be open to all registered members and invited guests.

Section 3—Sections

The House of Delegates or the Board of Trustees may provide for division of the scientific work of this Society into appropriate sections whenever necessity therefor arises.

ARTICLE IX—OFFICERS

Section 1—Term of Office

The Officers, except the Judicial Councilors and the elected members of the Board of Trustees, shall hold office for one (1) year, or until their successors are elected and installed.

Section 2—Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and the Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE X—FUNDS AND EXPENSES

Section 1—Finances

Current expenses of this Society shall be met by an annual assessment upon each component society in the ratio of its membership, by donation, by sale of this Society's publications, and from miscellaneous revenues.

During the annual meeting, funds shall be appropriated by the House of Delegates for the budgeted items, but for no other purpose, unless authorized by a two-thirds (2/3) vote of the members of the House of Delegates then present.

Section 2—Incurring Expense

The Board of Trustees may incur any necessary expenses between successive annual meetings.

ARTICLE XI—SEAL

The Seal heretofore adopted and now in use shall continue, unless otherwise ordered by the House of Delegates, to be the Seal of The Medical Society of New Jersey.



Seal of The Medical Society of New Jersey

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

This Constitution may be amended in the following manner:

A. Procedure for First Year

1. Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

2. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

3. Submission of the proposed amendment in writing at the first session of the House of Delegates.

4. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

5. Referral of the proposed amendment and report thereon to the appropriate reference committee.

6. Hearings on the proposed amendment and report thereon by the reference committee.

7. Report of the reference committee to the final session of the House of Delegates for appropriate action.

8. Acceptance by a majority vote of the members of the House of Delegates present and voting at the final session.

B. Procedure for Second Year

9. Transmittal of the accepted amendment to each component society and publication in THE JOURNAL, at least three (3) months prior to the next annual meeting.

10. Adoption by a two-thirds (2/3) vote of the members of the House of Delegates present and voting at the final sesion.

Offices to be Filled by Election

1958 Annual Meeting

Office	*Term*	*From*		*To*		*Incumbent*
President-Elect	1 year	May	1958	May	1959	Kenneth E. Gardner, Bloomfield
First Vice-President	1 year	May	1958	May	1959	F. Clyde Bowers, Mendham
Second Vice-President	1 year	May	1958	May	1959	Jesse McCall, Newton
Secretary	1 year	May	1958	May	1959	Marcus H. Greifinger, Newark
Treasurer	1 year	May	1958	May	1959	Rudolph C. Schretzmann, Bergenfield
Trustees:						
4th District	3 years	May	1958	May	1961	C. Byron Blaisdell, Asbury Park
5th District	3 years	May	1958	May	1961	Carl N. Ware, Shiloh
11th Trustee	3 years	May	1958	May	1961	Royal A. Schaaf, Califon
Councilor:						
3rd District	3 years	May	1958	May	1961	Charles H. Calvin, Perth Amboy
A.M.A. Delegates:	2 years	Jan.	1959	Dec.	1960	C. Byron Blaisdell, Asbury Park J. Wallace Hurff, Newark L. Samuel Sica, Trenton Elmer P. Weigel, Plainfield
A.M.A. Alternates:	2 years	Jan.	1959	Dec.	1960	Ralph M. L. Buchanan, Phillipsburg Jesse McCall, Newton Herschel Pettit, Ocean City John H. Rowland, New Brunswick
Delegates and Alternates to Other States:						
New York						
Delegate	1 year	1959 New York Convention				William F. Costello, Dover
Alternate	1 year	1959 New York Convention				Peter H. Marvel, Northfield
Connecticut						
Delegate	1 year	1959 Connecticut Convention				Lloyd A. Hamilton, Lambertville
Alternate	1 year	1959 Connecticut Convention				Levi M. Walker, (*) Atlantic City
Standing Committees:						
Finance and Budget	6 years	May	1958	May	1964	Anthony J. Conty, Union City
Publication	3 years	May	1958	May	1961	Joseph E. Mott, Paterson

(*) *Ad interim* appointment by Board of Trustees, 11/17/57, to fill vacancy in office created by death of Dr. Baxter H. Timberlake

Obituaries • • •

DR. FELIX BAUM

Dr. Felix Baum, one of the state's pioneer phthisiologists died on January 7, 1958, at the age of 74. Graduated in 1908 from the medical school of Leipzig University, Dr. Baum devoted himself to chest medicine in his native Germany until 1924. At that time he was invited to Denver to serve as medical director of the National Jewish Hospital there. A year later he was made Assistant Professor of Medicine at the University of Colorado. Two years later, he decided to move east and opened an office in Newark which he later moved to South Orange. He became affiliated with the staff of St. Mary's Hospital in Orange and was a consultant to the Essex County Tuberculosis Sanatorium in Verona. He was a Fellow of the American College of Chest Physicians and long active in the work of the American Trudeau Society.

DR. WILLIAM V. CARROLL

At the untimely age of 51, Dr. William V. Carroll died on January 13, 1958, at St. Francis Hospital, Trenton, where he was chief of the medical service. A native of Trenton, Dr. Carroll was graduated in 1930 from the medical school of Georgetown University. For many years he was township physician in Lawrence and was Commissioner of that township's Little League. At one time, Dr. Carroll was medical director of St. Francis Hospital.

DR. NORMAN N. FORNEY

One of Middlesex County's most colorful figures was the senior Dr. Norman N. Forney. He was a reporter and a bank president as well as a surgeon. He died November 25, 1957 on his 73rd birthday. Born in York, Penna., he worked as a youth as a reporter on a local newspaper there. He entered the Jefferson Medical College in 1902 and was graduated four years later. He then went to work as an assistant to a country doctor in rural Middlesex—that was in 1907—and for the remaining half-century he served the people of that area.

He was active in both New Brunswick hospitals, where he eventually became an attending surgeon. He was also active in county medical affairs, and had a busy term as president of the Middlesex County Medical Society. He was an F.A.C.S. and was also president of the National Bank in Milltown. He was also president of the Board of the local Methodist Church. He was Milltown's most active citizen and one of its most useful ones. The drug was never named for him.

DR. ALBERT S. HARDIN

The first pathologist in the city of Newark was Albert S. Hardin who, in 1905, assumed that post at St. Michael's Hospital. Dr. Hardin died in that hospital on November 22, 1957 at the age of 76. Born in Wheeling, West Virginia, he was graduated from the University of Maryland's medical school in 1901 at the age of 20. After doing graduate work in Vienna, he was invited to come to Newark to set up the pioneer laboratory at St. Michael's Hospital. Here he came and here remained for 52 years. He was surgeon to the Lackawanna Railroad, to the Essex County Park Commission, to the Presbyterian Hospital and to the Martland Medical Center. He was, for many years, an active member of the Newark Board of Health. He saw active duty in World War I. He was a founder of the Essex County Anatomical and Pathological Society, a founder of the Essex County Doctors' Chorus, an FACS, a senior Church Warden and an all around citizen.

DR. STEPHEN G. HOLSTER

A heart attack took the life of 56-year old Dr. Stephen G. Holster on December 12, 1957. Born and educated in Paterson, he was graduated in 1930 from the medical school of Yale University. Prior to his entry into medical school, he had been a college teacher and, for a while, was coach of the football team at Clifton High School.

Dr. Holster saw four years of very active naval service during World War II, finishing his naval career as a much decorated commander. In Paterson he was affiliated with both the St. Joseph Hospital and the Paterson General Hospital. He was active in veterans' organizations and in the Academy of General Practice.

DR. CHARLES A. RICHARDSON

At the grand age of 82, Dr. Charles A. Richardson died on December 8, 1957. An alumnus of the McGill Medical School (class of 1904) he interned in Brooklyn. He then moved to Closter, N. J. to open an office in 1908. Later he founded the Closter Medical Group. He was chief medical examiner for the Northern New Jersey Selective Service System during World War II.

When the Englewood Hospital created an obstetric service, Dr. Richardson became its first chief. He was also the Closter School Physician for many years.

DR. ROY B. SEELY

A past-president of the Mercer County Medical Society, Dr. Roy Brown Seely died on January 12, 1958, at the age of 68. A native of Paterson, he was graduated in 1914 from the Jefferson Medical College. Having thus been introduced to the Delaware valley, he decided he liked it, and has been serving the people of the Trenton-Philadelphia area ever since 1915. After interning in the Methodist Episcopal Hospital in Brooklyn, he returned to the Trenton area and opened an office for general practice. He gradually limited his interest to otology and ophthalmology and eventually just to ophthalmology. At the time of his death, he was chief of ophthalmology at the St. Francis Hospital in Trenton.

DR. HARRY B. SLOCUM

Dean of Monmouth County surgeons, Dr. Harry B. Slocum died on December 19, 1957. He had been doing surgery for more than half a century. Born in Long Branch in 1876, he was graduated in 1901 from the College of Physicians and Surgeons of Columbia University. After an internship in New York, he came to his native city and became affiliated with the Monmouth Memorial Hospital. He started in 1902 as a clinic physician and worked his way up through all ranks, becoming chief of staff in 1923. He remained chief of staff for almost 25 years. Declining renomination to that post in 1947, he continued as senior attending surgeon. He was the first physician to serve on the Board of Governors of that hospital. He was an F.A.C.S. In 1910 he was president of the Monmouth County Medical Society.

DR. HAROLD G. WALKER

On November 1, 1957, Dr. Harold G. Walker died at a Paterson Hospital. Dr. Walker was born in Paterson in 1889. He attended New York University where he received his medical degree in 1912, following which he served an internship at St. Joseph Hospital, Paterson. Early in his career he became interested in anesthesia and he was the first physician in this area to limit his practice to this specialty. In 1923 he was appointed attending anesthetist at St. Joseph Hospital, subsequently becoming head of this department. He served as president of the hospital staff during 1935. He was a diplomate of the American Board of Anesthesiology and in 1948 was one of the organizers of the Section on Anesthesia of The Medical Society of New Jersey.

During World War I he served in the United States Army Medical Corps with the rank of Major and during World War II he served with the rank of Captain in the United States Navy Medical Corps.

Medications for Cancer Patients

A new list of approved medications has been prepared under the direction of the Medical Committee of the American Cancer Society, New Jersey Division, Inc. of which Dr. George P. Koeck is chairman, and has been approved by the Society's Executive Committee.

The list includes medications most likely to be found necessary for the care of patients suffering from cancer. Prescriptions for these drugs will be paid for by the American Cancer Society when prescribed for a cancer patient approved as medically indigent under existing policy and program.

Physicians are asked to prescribe necessary medications at the lowest possible cost.

The medications are listed below for your information and future reference:

ACTH
Chlorpromazine
Meprobamate
Cortisone
Prednisone
Narcotics and other commonly employed pain allaying drugs such as morphine, codein and similar compounds
Nitrogen mustard
Tri-ethylene melamine
Antibiotics and bacteriostatic agents
Female and male sex hormones, such as stilbesterol, testosterone, both in the oral and injectable forms
4-amino-pteroylglutamic acid
1, 4-dimethanesulfonoxybutane (GT 41:myleran)
4-amino-N 10 methyl pteroylglutamic acid
Formyl tetrahydropteroylglutamic acid
6-mercaptopurine (Purinethol)
Sodium pteroyl triglutamate (Teropterin)

Announcements • • •

New Jersey Selected for Medical Care Study

Columbia University has selected New Jersey as the site for its long-awaited study of physicians' opinions about the quality of medical care. There have, of course, been many pronouncements on this subject—but very few have come from M.D.s. Under supervision of Columbia University such a study will now be undertaken. New Jersey physicians have been selected as a representative cross-section of modern practitioners. Doctors, selected by a formula, will be interviewed about their concepts of the factors that go into good medical care.

New Horizons for Psychoanalysis

On Wednesday evening, March 26, the Association for Psychoanalysis will hold the Sixth Annual Karen Horney Lecture. All physicians are welcome. The speaker is Abram Kardiner, M.D. and the topic is "New Horizons for Psychoanalysis." The meeting will be held at the New York City Academy of Medicine, 3 East 103 Street.

Course in Pediatric Oncology

General practitioners, pediatricians and health officers will be interested in an intensive full-time 3-day course covering the diagnosis and management of benign and malignant tumors of children. The course is given at Memorial Hospital East 68 Street, New York City and includes ward rounds, seminars, and clinical demonstrations. Tuition is $35. The class is limited. For more details write to Director of Pediatrics at the Memorial Center, 444 East 68 Street, New York, N. Y.

Fluoridation Facts for Speakers

Physicians called on to speak on fluoridation will find a kit of authoritative reference material available at convenient locations. You may also borrow such material, on a loan basis, from the State Department of Health.

Among other items, the kit contains reports from the National Research Council, and technical papers on the "Medical Aspects of Excessive Fluoride in a Water Supply," the "Nondental Physiologic Effects of Trace Quantities of Fluorine," and "Urinary Fluoride Levels Associated with Use of Fluoridated Waters."

The kit may be borrowed for one week, by writing to the Dental Health Program, New Jersey State Department of Health, Trenton 25, New Jersey.

Reference copies are also available at the following libraries:

Academy of Medicine of New Jersey
91 Lincoln Park
Newark, New Jersey

Fairleigh Dickinson University
School of Dentistry
Teaneck, New Jersey

Seton Hall University
College of Dentistry
Medical Center
Jersey City, New Jersey

National Honor for Seton Hall Dean

Dr. Charles L. Brown, dean of the College of Medicine at Seton Hall, was elected last month to the Committee on the National Formulary. He will head the National Formulary's Subcommittee on Pharmacology. This is Dr. Brown's second tour of duty on a national pharmaceutical body. In 1930, and for twenty years thereafter, he was a member of the Pharmacopoeial Revision Committee.

Letters to The Journal • • •

Dear Editor:

Recent restoration of the grave of Dr. William M. McKissack (1755-1831) of Bound Brook is of historical interest to The Medical Society of New Jersey. A new gravestone of marble was recently installed by the Grand Lodge, Free and Accepted Masons, for the State of New Jersey—replacing the original stone which was broken and neglected in the old Presbyterian graveyard at Bound Brook. A bronze plaque, which was dedicated in 1937 with appropriate Masonic ceremonies, has been transferred to the new tombstone. This plaque commemorates the fact that Dr. McKissack was the oldest Past Master present at the meeting in New Brunswick on December 18, 1784, when the Grand Lodge of New Jersey was organized. The legend reads: "In memory of Dr. William McKissack, founder of the Grand Lodge of Free and Accepted Masons for the State of New Jersey, December 18, 1784."

Dr. McKissack, a physician in Bound Brook for many years, was the last member elected to The Medical Society of New Jersey during the eighteenth century. He was received into membership at Princeton on November 3, 1795—being then a practitioner of many years' experience. In his *History of Medicine and Medical Men in New Jersey* (1879), Wickes tells us that Dr. McKissack "was widely known and esteemed, useful in his profession, and was regarded as a physician of good judgment and skill." His simple epitaph on the gravestone in the old Presbyterian graveyard at Bound Brook read, "William M. McKissack, M.D., Died Feb. 1831 in the 77th year of his age. His wife died Mar. 5, 1809 in the 51st year of her age."

Their son, Dr. William D. McKissack (1781-1853), who practiced at Millstone, became the 34th president of The Medical Society of New Jersey in 1826. A grandson, Dr. Peter Ditmars McKissack, who died in 1872, also practiced in Somerset County.

Restoration of Dr. William M. McKissack's grave site is a deserved tribute to this early physician, active in medicine and Freemasonry in New Jersey. It also attests the wide civic and communal interests of the pioneer medical doctors in this country.

Sincerely yours,

Fred B. Rogers, M.D.

Tay-Sachs Foundation

A new non-profit foundation has been established to support and stimulate research and educational programs in Tay-Sach's disease and allied heredo-familial, neuro-degenerative disorders of childhood. The program will include Tay-Sachs', Niemann-Pick's, Infantile Gaucher's, Schilder's disease, Diffuse Sclerosis, Amyotonia Congenita, Friedreich's ataxia, and others. The foundation is the National Tay-Sachs Association, Inc. It is composed of parents, who have had afflicted children, interested laymen, and medical personnel.

The foundation is cooperating with existing progress and with a project at the Jewish Chronic Disease Hospital in Brooklyn. The hospital is conducting a clinic for outpatient care of afflicted children. A genetic study is also being made of the hereditary patterns and a counseling program is offered.

To further its work and to prepare a genetic study, physicians and hospitals are requested to make the existence of the foundation known to parents of children afflicted with these diseases.

For further information write to Medical Committee, National Tay-Sachs Association, P.O. Box 1250, G.P.O., New York 1, N. Y.

County Society Reports • • •

Atlantic

The November meeting of the *Medical Society of Atlantic County* was held on November 8, 1957, at the Children's Seashore House. The meeting was called to order by the President, Dr. Levi Walker. The scientific program was a lecture given by Charles J. Barone, M.D., Professor of Obstetrics, University of Pittsburgh's School of Medicine. His subject was "Recent Advances in Obstetrics."

The business portion of the program began with committee reports. Dr. Major outlined the program for the Diabetes Detection Week, November 17 through November 23.

Dr. Holland described a booklet available through the A.M.A. which is an aid to the recording of family medical histories. A copy of this booklet will be sent to each member at the time of the delivery of the next *Bulletin*.

Dr. Walker suggested that any medical advertising appearing in the *Bulletin* would be reviewed by the Pharmaceutical Association.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* was held December 10, 1957.

The following newly elected Associate members were introduced: Michael J. Aria, J. Robert Botta, Jesse D. Greenberg, Herbert E. Keller, Lelio N. Passaglia, and William J. Ranucci.

The following Regular members received their member certificates and identification cards: Robert D. Eisenhauer, Gerda Hillyer, Robert E. Kahn, Thomas J. O'Connor, Sherwin H. Raymond, and R. E. Nelson.

The Secretary read the names of the following, all of whom had been recommended by the Membership Committee and approved by the Executive Committee:

To Regular from Associate—William N. Burke, Jerome Ferber, Sylvia K. Fried, Milton Greenberg.

To Regular by transfer—Alfred F. Grantelli (from Richmond Co. Med. Soc.), Harold R. Hanson (from Med. Soc. County of Albany), Marianne S. Ostrand (from Med. Soc. Co. of N. Y.).

To Associate—Elias Lika, Pauline Pellicano Territo.

On motion regularly made, seconded and passed, they were declared elected to their respective classes of membership.

A resolution memorializing Dr. Charles Albert Richardson was read by the Secretary and unanimously adopted.

Dr. Heller, chairman of the Public Relations Committee, announced that facilities had been developed for a single central telephone number to be called by the public in a medical emergency if the family physician and his alternate are unavailable. Additional volunteers are needed to increase the personnel of several of the eleven emergency call panels covering the county. Letters have been sent to all of the general practitioners and certain specialists established less than five years, in an effort to recruit additional volunteers.

Dr. J. P. O'Connor introduced the speaker of the evening, Dr. Ralph A. Deterling, Jr., a Courtesy Member of this Society and Associate Clinical Professor of Surgery, Columbia University. Dr. Deterling delivered a very instructive and interesting talk on the surgical management of arterio-sclerotic peripheral occlusive disease. His talk was well received and many questions from the floor were answered. These included brief dissertations of the value of sympathectomy and nerve crush as well as many others.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* convened December 3, 1957, at Cherry Hill Inn in Camden with Dr. Ralph S. Wright, presiding.

Drs. Melvin J. Andrews, Charles L. S. Brennan, Jr., Lawrence Kienle and Philip P. Levinson were introduced to the Society after taking the membership oath and signing the register.

The scientific program for West Jersey Hospital Night was prepared and presented under the chairmanship of Dr. William Most and consisted of: (1) Case presentation by West Jersey Hospital cardiovascular team; (2) Mesenteric cyst with hemorrhage, presented by Ralph A. Warwick, M.D., and William Kirkland, M.D.; (3) Hydrocephalic masquerading as schizophrenic, George A. Rogers, M.D., (4) Traumatic rupture of the liver, James R. Eynon, M.D. The president thanked Dr. Most for presenting the program.

Dr. I. Edward Ornaf, reporting for the Nominating Committee, presented the name of Dr. Stanley J. Okulicz as candidate for Alternate for Dr.

Robert N. Bowen, replacing Dr. David L. Andrus, previously elected Delegate. The name of Dr. Samuel V. Geyer as candidate for Alternate to fill the unexpired term of Dr. Penrose H. Thompson, deceased, was also presented. Drs. Leonard H. Dolof, Gordon R. Field and George E. Covintree were unanimously elected to membership.

The meeting adjourned at 10:40 p.m.

EUGENE H. KAIN, M.D.

Reporter

Hudson

With Dr. Harold Gorenberg presiding the *Hudson County Medical Society* held its regular meeting at Murdoch Hall, Jersey City Medical Center on Tuesday, December 3, 1957.

Reports were read from the Diabetes Committee, Dinner-Dance Committee and the Committee on Constitution and By-Laws.

A communication was read from the State Society concerning Bill A-245. A resolution was passed that the Hudson County Medical Society support the State Society in opposition to this bill.

A resolution was passed that $100 be donated to the Nurses' Fund at Murdoch Hall toward the purchase of a new set of dishes.

Elected to active membership: Drs. Kenneth W. Mahan, Jersey City, Frank Aquila, West New York and Lawrence J. Urban, Bayonne.

Guest speaker was Dr. Joseph Rogers, Assistant Professor of Medicine, Tufts University School of Medicine. His topic "Menstrual Abnormalities Related to Systemic Disease."

MATTHEW E. BOYLAN, M.D.

Reporter

Middlesex

The December meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. Gerard R. Gessner at 9:00 p.m. at the Roosevelt Hospital, Metuchen, December 18, 1957. The minutes of the November meeting were approved as read.

Applications for membership were approved as follows:

To two-year Associate membership—Dr. John Fenick, Sewaren; Sponsors: Drs. George J. Urban, Fords; Edward J. Novak, Woodbridge.

To Regular membership from two-year Associate membership—Dr. Eugene Trachtenberg, Edison; Sponsors: Drs. R. C. Steinman, Edison and E. R. Kant, Perth Amboy.

To Regular membership by transfer from the Bergen County Medical Society—Dr. Marshall Hewitt, Metuchen (with E. R. Squibb, New Brunswick); Sponsors: Drs. Martha F. Leonard and Hugh Williams, Highland Park.

The Public Relations Committee report was presented by Dr. William Rubin, Chairman, who spoke on medical emergency coverage. Most people felt that adequate care could be arranged by the individual doctor through the Physician's Exchange. Alternate plans were discussed whereby Rescue Squads or Police Departments could also facilitate coverage. The Society voted to authorize Dr. Rubin to set up an emergency call system in New Brunswick. If it works there, it will be tried throughout the county. A short film on Peripheral Vascular Disease was shown.

The meeting was adjourned and collation was served.

R. G. MATFLERD, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on Tuesday, November 19, 1957 at the Valley View Hospital. Dr. Samuel C. Yachnin, the President, called the meeting to order.

The following were elected to membership: *Active Members*—Drs. James A. Reilly of Preakness, Igor Sinchugov of Passaic, and Alvin Seligson of Fair Lawn; *Associate Members*—Drs. Elaine G. Kass and Bernard H. Sklar, both of Paterson.

The Secretary then read a resolution on the death of Dr. Harold G. Walker.

Dr. Yachnin acquainted the members with the substance of a *Legislative Bulletin* received from The Medical Society of New Jersey, in connection with proposed legislation A-245, concerning permission to non-citizens to be examined and receive temporary licenses to practice medicine. The Medical Society is opposed to this.

The meeting was then turned over to Dr. Homer H. Cherry, who introduced the guest speaker, William A. Briscoe, M.D., Assistant Professor of Medicine at Columbia University. Dr. Briscoe's subject was "Pulmonary Function in its Relation to General Practice," after which a question period followed.

Dr. Cherry, Superintendent and Medical Director of the Passaic County Valley View Hospital, then invited the members to a supper.

The regular monthly meeting of the *Passaic County Medical Society* was held on December 17, 1957 at the Medical Society Building. Dr. Samuel C. Yachnin, the President, presided.

The following were elected to membership: Active Member, Dr. Louis Z. Fautex, Jr. of Paterson; Associate Member, Dr. Richard Roukema of Ridgewood.

Dr. Yachnin reminded members that poliomyelitis reminder cards are available at the Public Relations Department of the American Medical Association. Physicians may, ethically, send these to their patients.

He acquainted the members with the contents of a communication received from the Hospital Service Plan of New Jersey, in connection with the intention of certain hospitals to cancel their agreements with the Plan.

The meeting was then turned over to Dr. Irving Ehrenfeld who introduced the guest speaker, Herbert S. Kupperman, M.D., Associate Professor of Medicine, New York University Graduate Medical School, and Chief of the Endocrinology Department of the Fertility Service, Margaret Sanger Research Bureau. A question period followed the scientific session.

Refreshments were then served by Mrs. Julian Cohen, Chairman of the Hospitality Committee of the Woman's Auxiliary, and a social hour was enjoyed by the more than average large attendance.

DAVID B. LEVINE, M.D.

Reporter

Salem

Dr. Robert Raydin of the Department of Surgery at the Hospital of the University of Pennsylvania addressed the regular monthly meeting of the *Salem County Medical Society* held December 20, 1957, at the DuPont-Penns Grove Country Club. Dr. Raydin is a son of Dr. Isidor S. Raydin, who operated on President Eisenhower last year. His subject was postoperative wound infections. Dr. Raydin described the recent increase in stubborn infections caused by the "golden staphylococcus" which have spread through whole hospitals, whole countries, and apparently the whole world.

Dr. Harry J. Knowles, Chief of the Surgical Department at the Elmer Community Hospital, was also a guest of the Society.

W. L. SPROUT, M.D.

Reporter

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Hospital Treatment of Alcoholism. Robert S. Wallenstein, M.D. Basic Books, New York 1957. Pp. 212. ($5.00)

Alcoholism is not a primary diagnosis but rather a symptom of an underlying personality disorder. This is confirmed by a recent research project conducted at the Veterans Administration Hospital in Topeka and reported in this book.

Active hospital treatment lasted three months with a two year follow-up period. Almost 200 patients were treated, each professing a need for treatment. Each considered himself a chronic alcoholic. Four different methods of treatment were evaluated: (1) Antabuse®, (2) conditioned reflex method, (3) hypnotherapy, and (4) closed ward milieu therapy. The last group, though originally considered a control, did include psychotherapy. Every three months 20 new patients were admitted and randomly divided into 4 equal groups. Each ward was given a different method of treatment. No selection was permitted. After three months they were discharged and carried by the same physician in the out-patient department where they reported regularly.

All patients were classified in one of three diagnostic rubrics: psychotics (schizoid and paranoid individuals), character disorders, and neurotics. Improvement was appraised on the degree of abstinence, social adjustment, subjective feelings of difference and structural changes in personality configuration. In three modalities improvement was found to be about equal while in the fourth, it was considerably higher, although even in this group, the improvement was only 53 per cent.

Cutting across all diagnostic categories, definite personality traits were found to respond to certain therapies. Character trends such as passivity, dependency, aggressiveness, and compulsiveness tended to correlate positively with specific treatments. Ability to relate with the physician, the project, and the hospital, was a strong positive factor in all four methods of treatment.

THEODORE ANDERSON, M.D.

Epilepsy and the Law. By Roscoe L. Barrow and Howard D. Fabing, M.D. Hoeber and Harper. New York 1956. Pp. 192. ($5.50)

Epilepsy and the Law is a compact, easily read account by a lawyer and neuropsychiatrist of the state laws affecting the legal status of epileptics. The authors stress anachronistic concepts which create social climate unfavorable to rehabilitation of epileptics. This is particularly distressing since 50 per cent of epileptics achieve a complete control of seizures with modern drugs while 30 per cent achieve a partial control. Laws affecting epileptics unfavorably deal with issuance of marriage

and driver's licenses, workmen's compensation, immigration, commitment to institutions and education. Seventeen states including New Jersey forbid marriage of epileptics. In 20 states sterilization laws affect epileptics. No distinction is made between symptomatic and genetic epilepsy.

Laws indiscriminately forbidding issuance of driver's licenses to epileptics create traffic hazards since they force the patients not to report their condition. The Wisconsin law (permitting issuance of driver's licenses after a 2 year period of freedom from seizures) is cited with approval. The Wisconsin experience shows that patients with controlled seizures are safe drivers. Workmen's compensation discrimination promotes resistance of employers to hire epileptics; yet epileptics with infrequent seizures are reliable workers and no more accident prone than non-epileptic employees. To encourage employment of epileptics the authors suggest the application to epileptics of the Second Injury Fund or of the "Encouragement of Employment of the Handicapped" legislations. This would relieve the employer from payment of the part of the award contributed by pre-existing impairment.

The text is followed by a verbatim transcription of many bills and statutes affecting the epileptics. A comprehensive and detailed index ends the volume. The book is characterized by clarity and extraordinary substance. It will be of great use to physicians, lawyers and rehabilitation workers. It is now available in the Library of the Academy of Medicine of New Jersey.

EUGENE REVITCH, M.D.

The Chronically Ill. By Joseph Fox, Ph.D. New York 16, N. Y. 1957. The Philosophical Library. Pp. 229. ($3.95)

Our blessed land is the most prosperous country on earth. Yet its provision for chronic illness is shameful. A long-term disability first drains out all of a man's savings. It then deprives his children of further education or constitutes a mill-stone around *their* necks depriving *their* children of the good things of life. It leads finally to a subsistence-level of life in an institution. Hospitals generally shoo away the chronic patient—a word which they brutally shorten to "crock." One would suppose that the mind of man which cracked the secrets of the atom is capable of solving this problem too; and that the wealthiest republic on earth can do better than we are doing for its sick citizens.

The author, Executive Director of the Home for the Chronic Sick here in Irvington, explores the problem and sets up guide lines. He has no magic formula—but at least he has a plan. He reviews the economic, administrative, sociologic and human aspects of the problem. If the text suffers from a pedestrian pompousness of style, it is also fused with a zeal for rehabilitation and an unwillingess to write off *any* human being.

HERBERT BOEHM, M.D.

Physicians' Federal Income Tax Guide. By H. J. Campbell, J. B. Liberman and H. D. Shereff. Great Neck, N. Y. Channel Press 1958. Pp. 94. Paper. ($2 50)

That time is here again. Most private practitioners are well advised to have an accountant prepare the income tax return. If for any reason you insist on being your own doctor, this booklet will be helpful. It carries an alphabetized list of deductions (alimony to safe deposit box rental) and even discusses the tax status of fee-splitting. While none of our readers would be interested in this, the rule is that the payment of compensation for referring patients *is* deductible if it is an ordinary and necessary expense in the promotion of practice and if it is customary in the community.

The book takes the reader in hand and conducts him step by step through the lines of form 1040. It includes a sample form filled out in detail. It covers medical society dues, malpractice insurance payments, calculation of depreciation and tells you whether you can deduct a traffic fine incurred while speeding to a dying patient. (You can't). This book costs $2.50 which seems a stiff price for a 94-page, paper-covered brochure. But after all, $2.50 is deductible.

ULYSSES M. FRANK, M.D.

One Surgeon's Practice. By Frederick Christopher, M.D. Saunders, Philadelphia, 1957. Pp. 140. ($4.00)

Dr. Christopher is the well known author of *Minor Surgery* which he carried through six editions. He has a broad background of technical and clinical experience, plus a skill in writing of every day medical matters in a stimulating fashion.

He covers such topics as choice of location, non-operative hospital activities, non-professional activities, personal injury litigation and surgical fees in a practical and realistic fashion that could be the reflections only of a man who is a surgeon's surgeon.

The chapter on surgical pitfalls is of particular interest to any physician who has ever wielded a scalpel. He emphasizes that the surgeon must alert himself continually to the possibility of errors of judgment on technic and never think of any procedure as "easy." He discusses the possibility of operating on the wrong side, silk or cotton knots as cause of sinuses, incorrect diagnoses and the obtaining of autopsies.

The chapters on surgical teaching and surgical writing are of particular interest to the university surgeon and in this day of extensive residency training should be an inspiration to any member of a teaching hospital.

Dr. Christopher has written this short autobiography in a language which is easily followed. This book should be helpful to the surgical resident and should be on the bedside table of every surgeon.

GEORGE F. HEWSON, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI February 1958 No. 2

TREATMENT OF TUBERCULOSIS IN THE ELDERLY INDIVIDUAL

By Thomas J. Kinsella, M.D., Geriatrics, June 1957.

Many changes have occurred in the clinical and epidemiologic picture of tuberculosis in the past twenty-five years, one of which has been a change in age distribution. A quarter of a century ago, tuberculosis was considered to be a disease of young people, with the older age groups relatively immune or having it in a rather benign chronic form. They were the true consumptives who never died of their disease and never recovered from it. Frequently not much attention was paid to the elderly individual, even though he had some trouble with a chronic cough until a grandchild or great grandchild died of tuberculosis meningitis, thus establishing the diagnosis.

The Shift in Age Group.—At Glen Lake Sanatorium (Minn.) in 1925 the typical patient admitted was a young woman in her late teens or 20's. The situation today is totally different. The typical admission patient is a man, 50 or above, who may be a drifter or an alcoholic. Likewise, in 1925 at Glen Lake only nine percent were the age of 50; in 1955, over 40 per cent were in this age group. Somewhat comparable figures come from nearby sanatoriums.

We must realize, of course, that many of the individuals who are now being admitted to the tuberculosis sanatoria with active tuberculosis belong to the same generation as the patients who were being admitted to the institutions some twenty-five to thirty years ago. Did they receive their contamination long ago and only now develop their active disease, or did they escape at that time to be contaminated at a subsequent date? The clinical picture, in some at least, would seem to suggest a more recent exposure, for there is frequently little to show for any old disease. In 1925, there was much discussion of preventoria and institutions for the treatment of younger individuals. The emphasis now is on institutions for elderly individuals. The numbers of older individuals in our population have increased and we should expect more of them in public institutions.

Where is Tuberculosis Found?—The first and most important thing that the average physician must realize is that pulmonary tuberculosis is a disease of the human race and is present among all ages, races, and in all strata of society. A generation ago, when the disease was more prevalent, all physicians were constantly confronted with it. Nowadays with its low incidence and its low mortality, it is frequently overlooked in a differential diagnosis. The younger generation of physicians has been taught to fear the condition and has been shielded from any first-hand knowledge of it. Is it any wonder, then, that the condition is frequently overlooked?

Tuberculosis in the aged may present itself in a typical and easily recognized fashion. It is perhaps a little more likely to be masked by or confused with chronic bronchitis, bronchiectasis, pulmonary abscess, pulmonary infarcts, bronchogenic carcinoma, atypical pneumonia, virus pneumonia, or various other conditions. Tuberculosis is where you find it, and it may only be discovered by intensive search. Even when the physician is suspicious and submits a sputum specimen to the average laboratory, the specimen is frequently sent on to the State Board of Health for culture, thus delaying the diagnosis for an extra six to eight weeks.

Diagnosis.—A high index of suspicion of tuberculosis is of great value to the physician when he confronts a patient with chest complaints and particularly when the patient is an elderly individual who may present a ready-made diagnosis. The diagnosis of asthma, bronchitis, bronchiectasis, pneumonia, virus pneumonia and unresolved pneumonia, hay fever, allergy, emphysema, smoker's cough, or cigarette cough may not only hide a multitude of sins but millions of tubercle bacilli. The problem is the more difficult when the patient actually has two or three conditions at

one time, such as carcinoma and tuberculosis, bronchiectasis and tuberculosis, asthma and tuberculosis, and so on. It may be that the presence of tuberculosis can be ruled out or confirmed only by a careful history, physical examination, X-ray studies, and repeated laboratory studies.

The prevalence of tuberculosis among patients with diabetes, gastric resections, chronic alcoholism, insanity, and other debilitating conditions is sometimes not properly appreciated by physicians. When there is a known history of exposure to the disease it is a mistake to check the individual once or perhaps twice over a period of a few months and overlook the fact that clinical disease may be slow to develop or may not become evident until some debilitating process lowers the resistance.

Another common mistake lies in assuming that a few fibroid or calcified deposits in one apex have no clinical significance. This is especially true when such findings are recorded on routine survey films, since the patient is entirely asymptomatic. Even more pernicious is the categorical statement by a roentgenologist that a certain lesion is of no clinical significance. Activity or communicability of tuberculosis cannot be accurately determined from X-ray studies alone. This requires careful clinical and laboratory study, often over long periods.

The course of pulmonary tuberculosis in the elderly individual varies widely. There are some who present acute exudative disease which progresses rapidly and apparently is of very recent development. Many others have chronic disease which smolders at a very slow rate with only intermittent spells of activity and liberation of tubercle bacilli. The same manifestations may be observed when the patient is under treatment.

Treatment.—Fundamentally the treatment of pulmonary tuberculosis in the aged is much the same as in other age groups, but with certain exceptions. Isolation and treatment in a sanatorium are best for all concerned. Before the advent of chemotherapy, much reliance was placed on bed rest, but it was found that prolonged intensive bed-rest treatment was not well tolerated, either mentally or physically. Complications in the form of decubitus ulcers, nutritional disturbances, contractures, hypostasis, and thrombotic phenomena occurred too commonly. A more modern approach, is a program of intensive therapy with two of the drugs, streptomycin, isonicotinic acid hydrazide (INH), and paraaminosalicylic acid (PAS), using only a moderate restriction of physical activities. Under such a program, many individuals, of advanced years, handle their tuberculosis very well. In this category, the advantages of prolonged chemotherapy cannot be overrated, for many individuals are left with sufficient residual disease to render the danger of relapse without drug therapy very real.

Collapse Therapy.—Collapse therapy of various types, such as artificial pneumothorax, extrapleural pneumothorax, plombage, or limited thoracoplasty, which have been largely abandoned in the treatment of tuberculosis in younger individuals, could perhaps find a use with chemotherapy for the possible closure of cavity, control of bleeding, or other symptoms in elderly individuals among whom the more definite resection procedures would be unduly hazardous.

Resection and Other Thoracic Surgery.—Modern chemotherapy, blood transfusions, and modern anesthesia have now made it possible to carry out many major surgical procedures on patients of advanced years. It is definitely physiologic age and associated conditions, rather than attained age, which is important.

There are many factors, that affect the surgical risk in older patients and each factor must be carefully studied in each individual before surgical treatment can be undertaken. From the standpoint of the respiratory system alone, the extent of the patient's disease, the amount of lung or breathing space that must be sacrificed, the vital capacity, the amount of limitation of chest wall and diaphragmatic motion, and the amount of emphysema present must be carefully evaluated. There is little virtue in curing a patient of his tuberculosis if in the process he becomes a respiratory cripple.

We cannot rehabilitate many of these patients, but if we can return them to their families without risk of contamination, it is worth the effort.

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1. Axelrod, A. E.; Beaton, J. R.; Cannon, P. R., and others: Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Incorporated, (March) 1954, p. 100.

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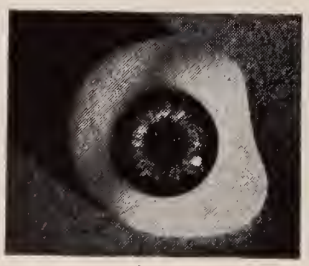
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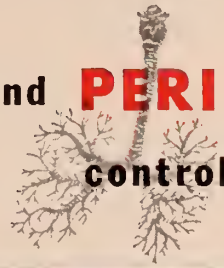
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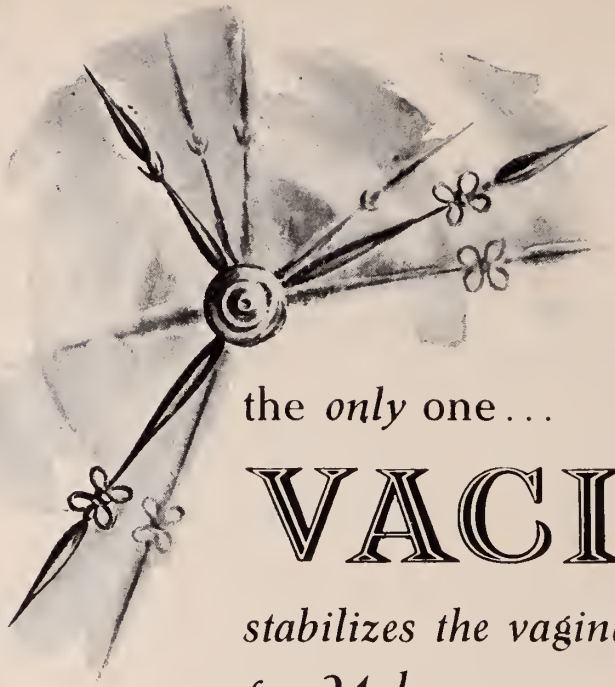
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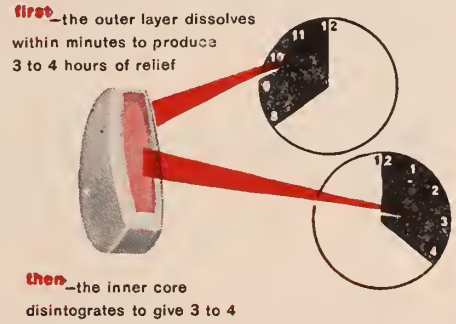
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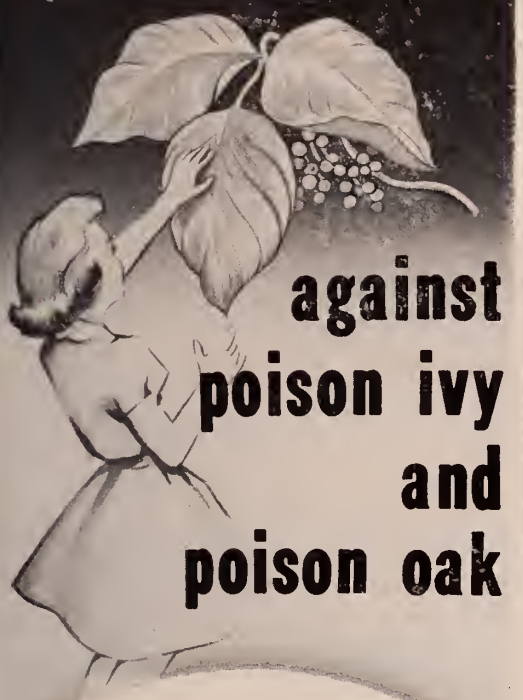
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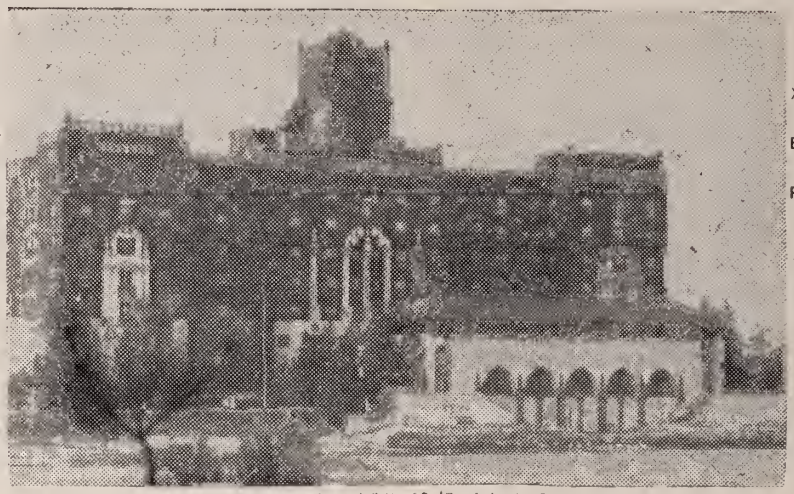
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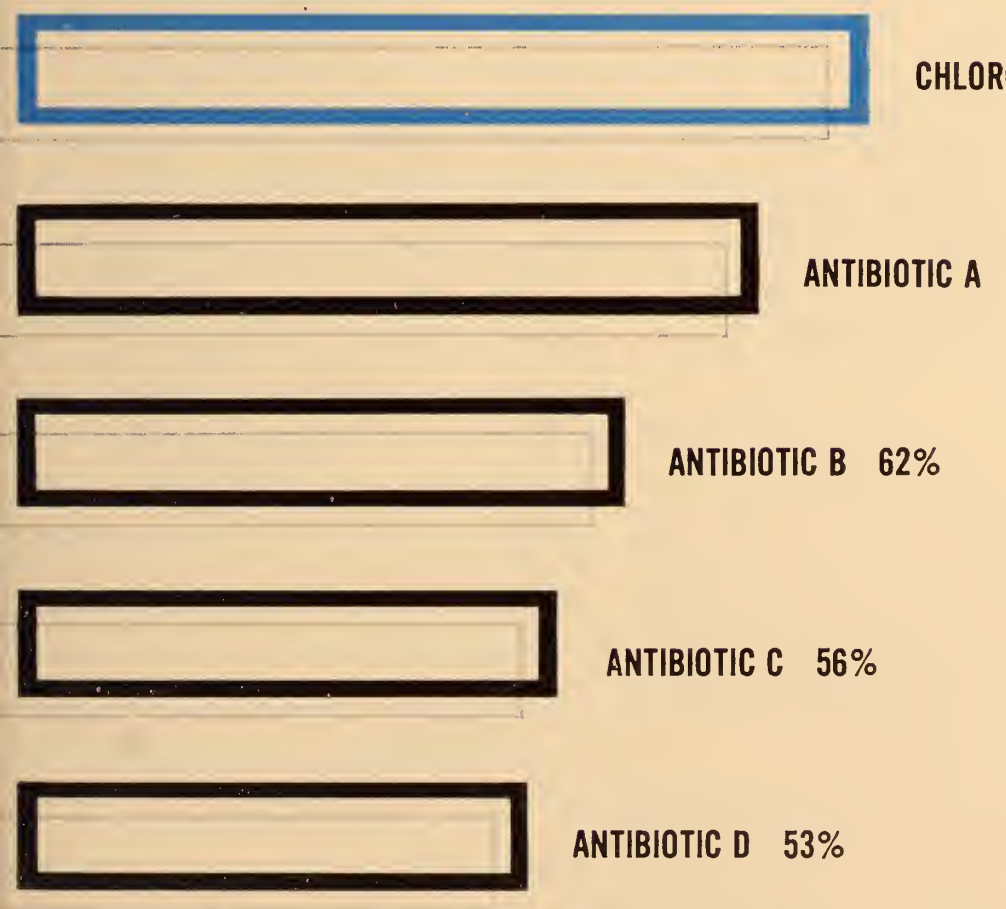
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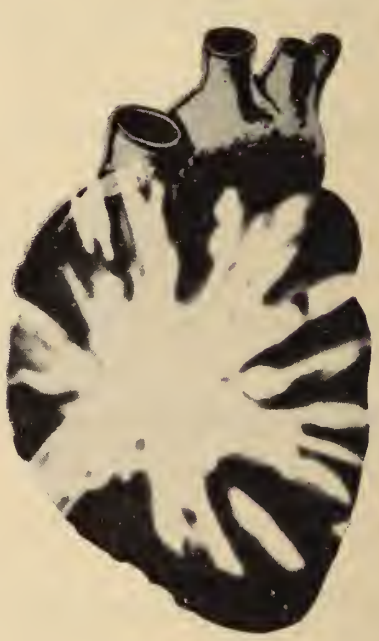
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THE MEDICAL SOCIETY OF NEW JERSEY

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- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- those on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin) — Sumycin plus Mycostatin

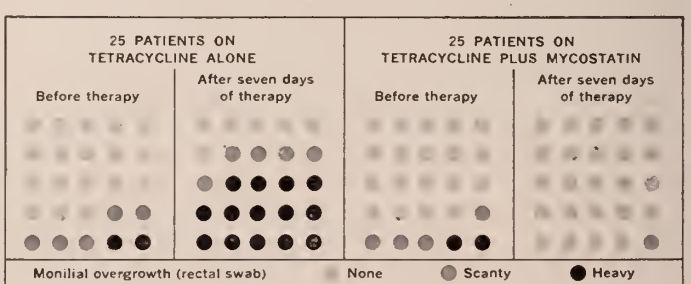
for practical purposes, Mysteclin-V is sodium-free

for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.

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Childs, A. J.: British M. J. 1:660 1956.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u.), 10 cc. dropper bottles.

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a superior psychochemical
for the management of both
minor and major
emotional disturbances



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dihydrochloride — brand of thiopropazate dihydrochloride

- more effective than most potent tranquilizers
- as well tolerated as the milder agents
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Dartal is a unique development of Searle Research, proved under everyday conditions of office practice

It is a single chemical substance, thoroughly tested and found particularly suited in the management of a wide range of conditions including psychotic, psychoneurotic and psychosomatic disturbances.

Dartal is useful whenever the physician wants to ameliorate psychic agitation, whether it is basic or secondary to a systemic condition.

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Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

Usual Dosage
- In psychoneuroses with anxiety and tension states *one 5 mg. tablet t.i.d.*
- In psychotic conditions *one 10 mg. tablet t.i.d.*

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for us



- Symptomatic relief of aches, pains, fever, coryza, and rhinorrhea associated with upper respiratory tract infections.
- Prevention of secondary pyogenic infections due to tetracycline-sensitive organisms — which often follow viral infections of the upper respiratory tract.

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MEDICATION

"flu," "grippe," "virus" and the common cold

Tetrex®-APC

with BRISTAMIN

TETRACYCLINE PHOSPHATE COMPLEX WITH PHENYLTOLOXAMINE AND APC

Each TETREX-APC WITH BRISTAMIN Capsule contains:

A broad-spectrum antibiotic

TETREX (tetracycline phosphate complex) ..... 125 mg.
(tetracycline HCl activity)

An established analgesic-antipyretic combination

Aspirin ..... 150 mg.
Phenacetin ..... 120 mg.
Caffeine ..... 30 mg.

A dependable antihistamine

BRISTAMIN (phenyltoloxamine, Bristol) ..... 25 mg.

Dosage: *Adults:* 2 capsules at onset of symptams, followed by 2 capsules 3 or 4 times a day for 3 to 5 days. *Children, 6 to 12 yrs.:* One-half adult dose.

Supplied: Bottles of 24 and 100 capsules.



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Standard formulas for PREMATURES

Breast milk is satisfactory for the feeding of prematures in spite of the low protein and mineral and high fat content. But eventual formula feeding should provide a high protein and carbohydrate to satisfy the rapid-growing needs of the premature and low fat content because of limited digestive capacity.

Feedings of small prematures are most effectively administered by the indwelling polythene nasal catheter and of large prematures, by bottle with small nipples.

The first six feedings should be a sterile 5% solution of Karo Syrup at 2 to 3 hour intervals; for subsequent feedings, breast milk or formula should be added in gradually increasing amounts according to tolerance and requirements, as indicated in the table below.

Initial feeding schedules for premature infants

(Feedings Started After 36 Hours and Continued at 2 to 3 Hour Intervals)

FEEDINGS	COMPOSITION	QUANTITY
First Six	5% Karo	2-5 ml.
7th and 8th	2 parts 5% Karo 1 part breast milk or formula	6-10 ml.
9th and 10th	1 part 5% Karo 1 part breast milk or formula	8-15 ml.
11th and 12th	1 part 5% Karo 2 parts breast milk or formula	10-18 ml.
Subsequently	Breast or formula feeding	12-20 ml.

ADVANTAGES OF KARO® IN INFANT FEEDING



Composition: Karo is a superior maltose-dextrin mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no further digestion.

Concentration: Volume for volume Karo furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

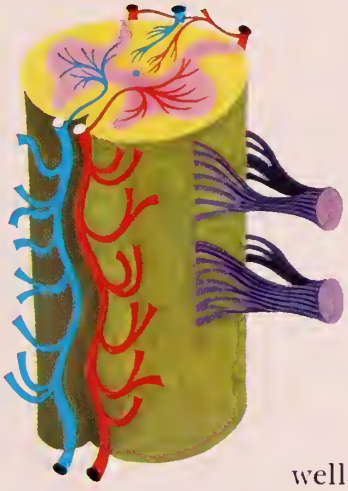
Low Cost: Karo costs 1/5th as much as expensive milk modifiers and is available at all food stores.

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relaxes both mind & muscle

without impairing mental or physical efficiency





well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets. *Usual dosage:* One or two 400 mg. tablets t.i.d.

For anxiety, tension and muscle spasm in everyday practice.

Miltown®

tranquilizer with muscle-relaxant action

2-methyl-2-n-propyl-1,3-propanediol dicarbamate



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**Belafsky, H. A., Breslow, S. and Shangold, J. E.: Meprobamate in pregnancy. Obst. & Gynec. 9:703, June 1957.*

Miltown®



THE ORIGINAL MEPROBAMATE
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WALLACE LABORATORIES
NEW BRUNSWICK, NEW JERSEY

CM-5571

ACHROCIDIN*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula offering in one tablet the drugs often prescribed separately for treating upper respiratory infections.

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Early effective therapy is provided against such bacterial complications as sinusitis, otitis, bronchitis and pneumonitis to which the patient may be highly vulnerable at this time.

Adult dosage for ACHROCIDIN Tablets and new, caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children reduced according to weight and age.

Available on prescription only.

TABLETS *(Sugar-coated)*
Each tablet contains:

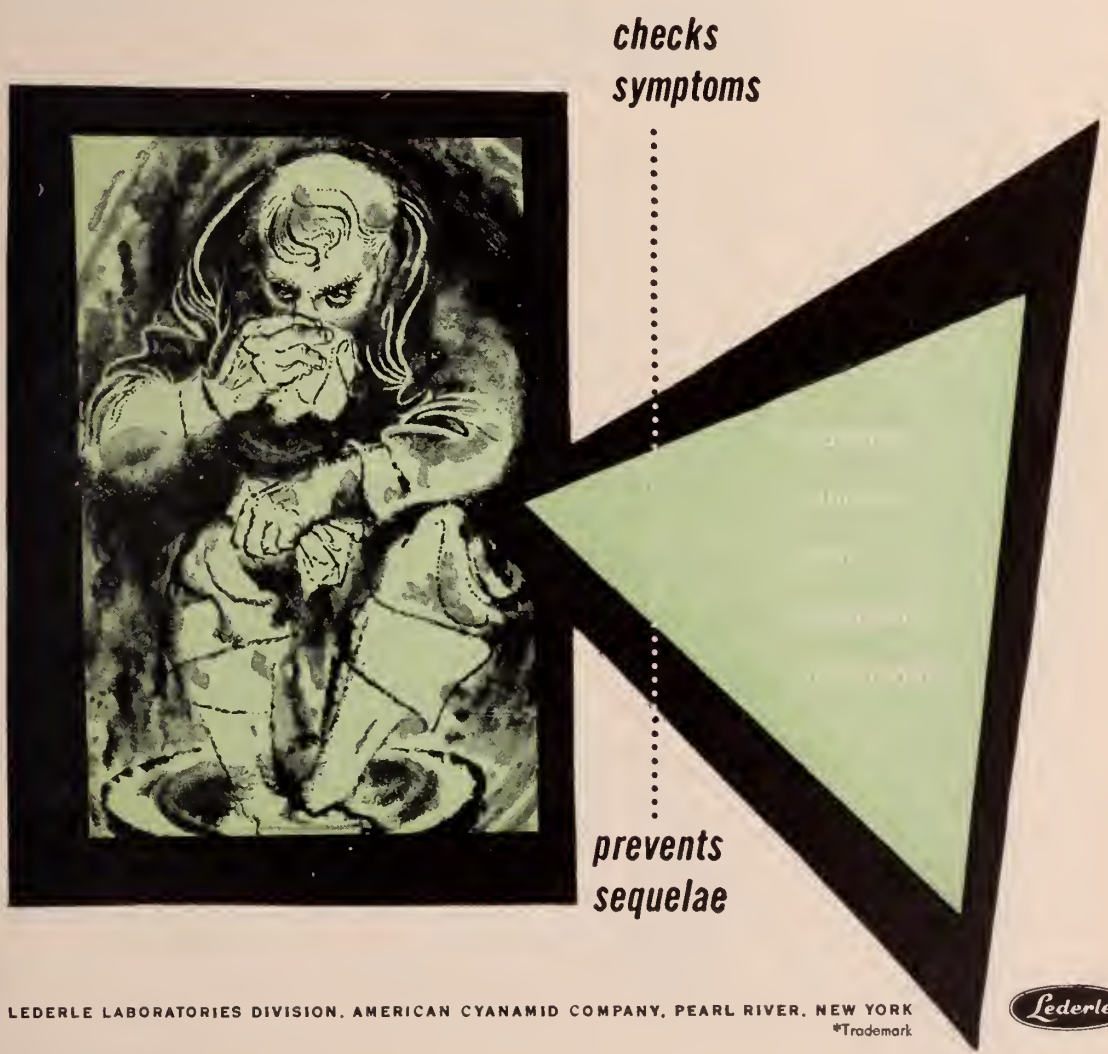
ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100

SYRUP *(Lemon-lime flavored)*
Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK
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'DIURIL'

(CHLOROTHIAZIDE)

in

EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

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as simple
as 1-2-3
in

HYPERTENSION



1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'

Meat...

and Protein Nutrition in Vascular Disease

Whether the eventual solution of the problem of atherogenesis will come out of the field of dietetics, biophysics, or pharmacology, one fact remains undeniable:

Adequate protein nutrition is considered of importance for the age group most commonly affected by disease of the vascular system, so that the demands of good nutritional health might be met.

Meat is outstanding among protein foods. It supplies all the essential amino acids, and closely approaches the quantitative proportions needed for biosynthesis of human tissue.

In addition, it is an excellent source of B vitamins, including B_6 and B_{12}, as well as iron, phosphorus, potassium, and magnesium.

When curtailment of fat intake is deemed indicated, meat need not always be denied the patient. Visible fat obviously should not be eaten. But the contained percentage of invisible (interstitial) fat is well within the limits of reasonable fat allowance.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

TASTY, FAST-ACTING ORAL FORM OF CITRATE-BUFFERED ACHROMYCIN V



ACHROMYCIN* V

TETRACYCLINE BUFFERED WITH SODIUM CITRATE

SYRUP

aqueous

ready-to-use

freely miscible

- accelerated absorption in the gastro-intestinal tract
- early, high peaks of concentration in body tissue and fluid
- quick control of a wide variety of infections
- unsurpassed, true broad-spectrum action
- minimal side effects
- well-tolerated by patients of all ages

ACHROMYCIN V SYRUP:
Orange Flavor. Each teaspoonful (5 cc.) contains 125 mg. of tetracycline, HCl equivalent, citrate-buffered. Bottles of 2 and 15 fl. oz.

DOSAGE:
6-7 mg. per lb. of body weight per day.

*Reg. U.S. Pat. Off.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK



"finger-itis"

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1]

. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

. . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more manageable corticosteroid dosage

. . . much less likelihood of treatment-interrupting side effects[1-6]

. . . simple, flexible dosage schedule



in any case
it calls for

Sigmagen®

corticoid-salicylate compound

tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

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new study[1] shows why

arlidin®

brand of nylidrin hydrochloride N.N.R.

is a more consistently dependable peripheral vasodilator

Arlidin is often effective when other vasodilators fail . . . because it brings more blood where needed most . . . in distressed skeletal muscle.[1]

Arlidin produced improvement in rest pain and ulcers, reduction in swelling and increased walking distance in a majority of 79 patients with . . .



intermittent claudication

in

arteriosclerosis obliterans

thromboangiitis obliterans
(Buerger's disease)

. . . also effective in

abdominal aortic occlusion

chronic venous insufficiency

Available as tablets and injectable solutions. See P.D.R. for dosage.

1. Murphy, H. L., and Klasson, D. H.: New York St. J. M. 57:1908, June 1, 1957

SAMPLE supply of Arlidin and complete reprint upon request

arlington-funk laboratories

division of U. S. VITAMIN CORPORATION • 250 East 43rd Street, New York 17, N. Y.

protected by U.S. Patent Numbers 2,661,372 and 2,661,373

NOW—FROM ABBOTT LABORATORIES



AN ANTIBIOTIC TRIAD —FOR THE CONTROL OF ALL COCCAL INFECTIONS

FILMTAB®

Erythrocin®

STEARATE (Erythromycin Stearate, Abbott)

against staph-, strep- and pneumococci



Indications

ERYTHROCIN is indicated in treating infections caused by staphylococci, streptococci (including enterococci), and pneumococci. Indicated also, in treating infections that have become resistant to other antibiotics. May be used for patients who are allergic to penicillin or other antibacterials.

Dosage

Usually administered in a total daily dose of 1 to 2 Gm., depending on severity of infection. Suggested dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours.

Supplied

In bottles of 25 and 100 *Filmtabs* (100 and 250 mg.). Also, in tasty, cinnamon-flavored oral suspension, in 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.



REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension. Abbott

802069

Compocillin-V®

for those penicillin-sensitive organisms



802071

Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

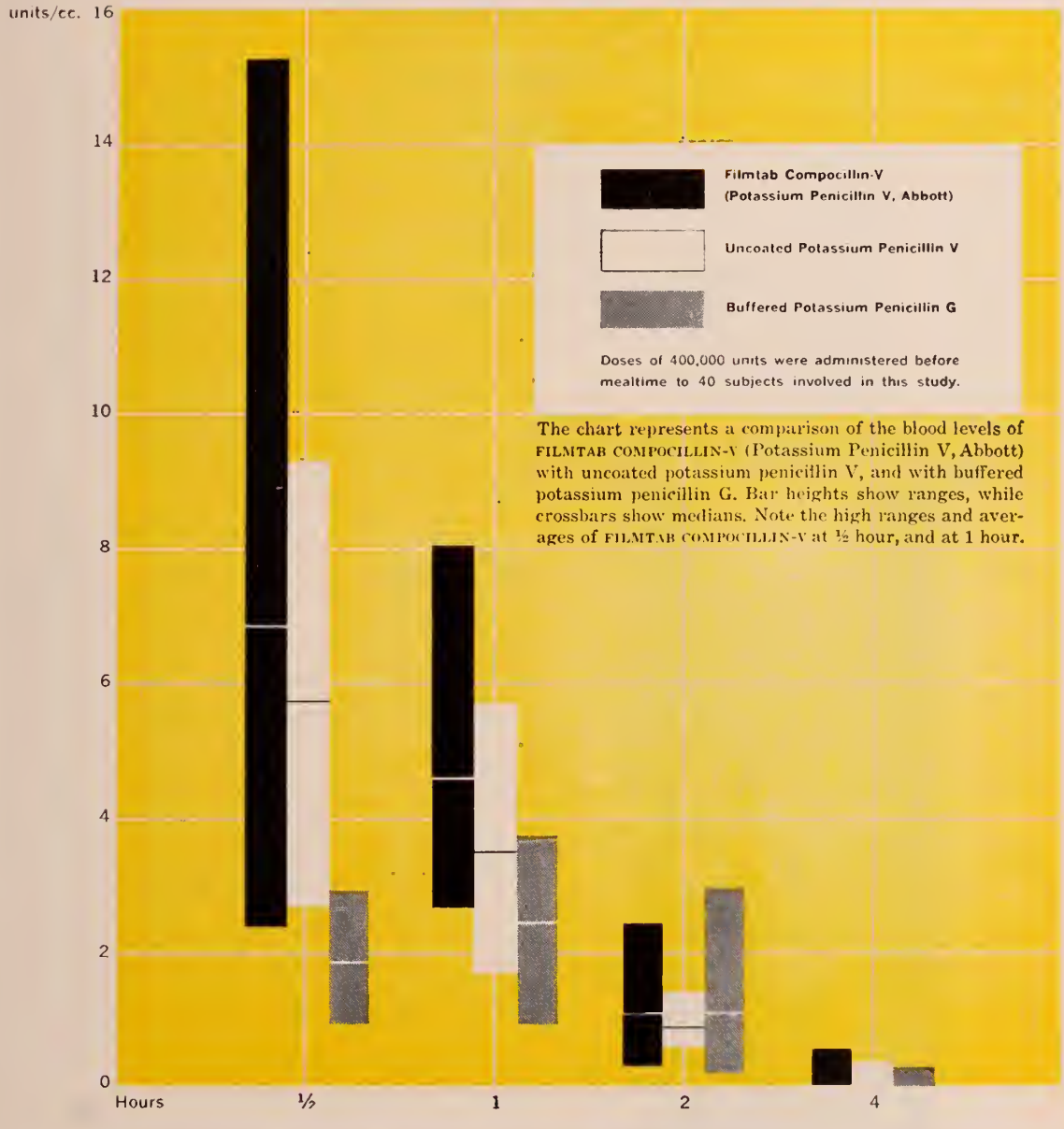
Dosage

Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

Abbott

Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient



802070

Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED



SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

Abbott

A NEW, CORTICOSTEROID MOLECULE WITH GREATER ANTIALLERGIC, ANTIRHEUMATIC AND ANTI-INFLAMMATORY ACTIVITY



for your patients with

- BRONCHIAL ASTHMA, ALLERGIC DISORDERS
- ARTHRITIC DISORDERS
- DERMATOSES

Squibb Triamcinolone

KENACORT

- far less gastrointestinal distress
- safe to use in asthma with associated cardiac disease; no sodium and water retention
- does not produce secondary hypertension—low salt diet not necessary
- no unnatural psychic stimulation
- often works when other glucocorticoids have failed
- and on a lower daily dosage range

SQUIBB

Initial dosage: 8 to 20 mg. daily. After 2 to 7 days gradually reduce to maintenance levels.
See package insert for specific dosages and precautions.
1 mg. tablets, bottles of 50 and 500.
4 mg. tablets, bottles of 30 and 100.

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Squibb Quality—the Priceless Ingredient

"KENACORT" IS A SQUIBB TRADEMARK

NOW

COUNTERACT DEPRESSED MOODS *without stimulation*

- Relieves depression without euphoria —*not a stimulant*
- Restores natural sleep without depressive aftereffects —*not a hypnotic*

- Rapid onset of action
- Side effects are minimal and easily controlled

▲Deprol▲

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. benactyzine HCl

Average Adult Dose: 1 tablet q.i.d.

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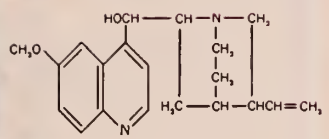
Progress in SYNTHETIC CHEMISTRY EQUALS Progress in CHEMOTHERAPEUTICS

"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

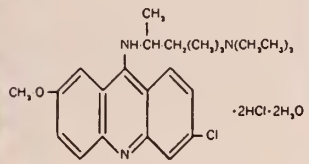
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

". . . the least toxic of its class . . ."[3]

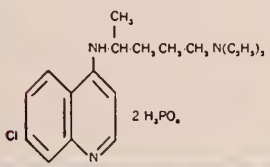
QUININE



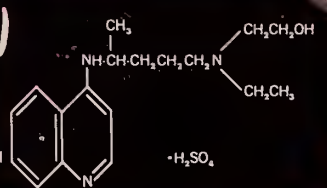
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Plaquenil® SULFATE

Remarkably effective in RHEUMATOID ARTHRITIS

SIDE EFFECTS MARKEDLY REDUCED

DOSE: **Initial** — 400 to 600 mg. (2 or 3 tablets) Plaquenil sulfate daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100.

Write for Booklet

Winthrop LABORATORIES NEW YORK 18, N. Y.

REFERENCES:

1 Scherbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
2. Editorial: *Bull A. Mil. Dermatologists*, The Shock Section 5:25, Nov., 1956.

Atabrine (brand of quinacrine), Aralen (brand of chl
and Plaquenil (brand of hydroxychl

NOW...A NEW TREATMENT

'CARDILATE'*

for THE PROPHYLAXIS OF ANGINA PECTORIS

'Cardilate' tablets  shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored



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SULFASUXIDINE®* PECTIN-KAOLIN-NEOMYCIN SUSPENSION

SOOTHING ACTION . . . Kaolin and pectin coat and soothe the inflamed mucosa, adsorb toxins and help reduce intestinal hypermotility.

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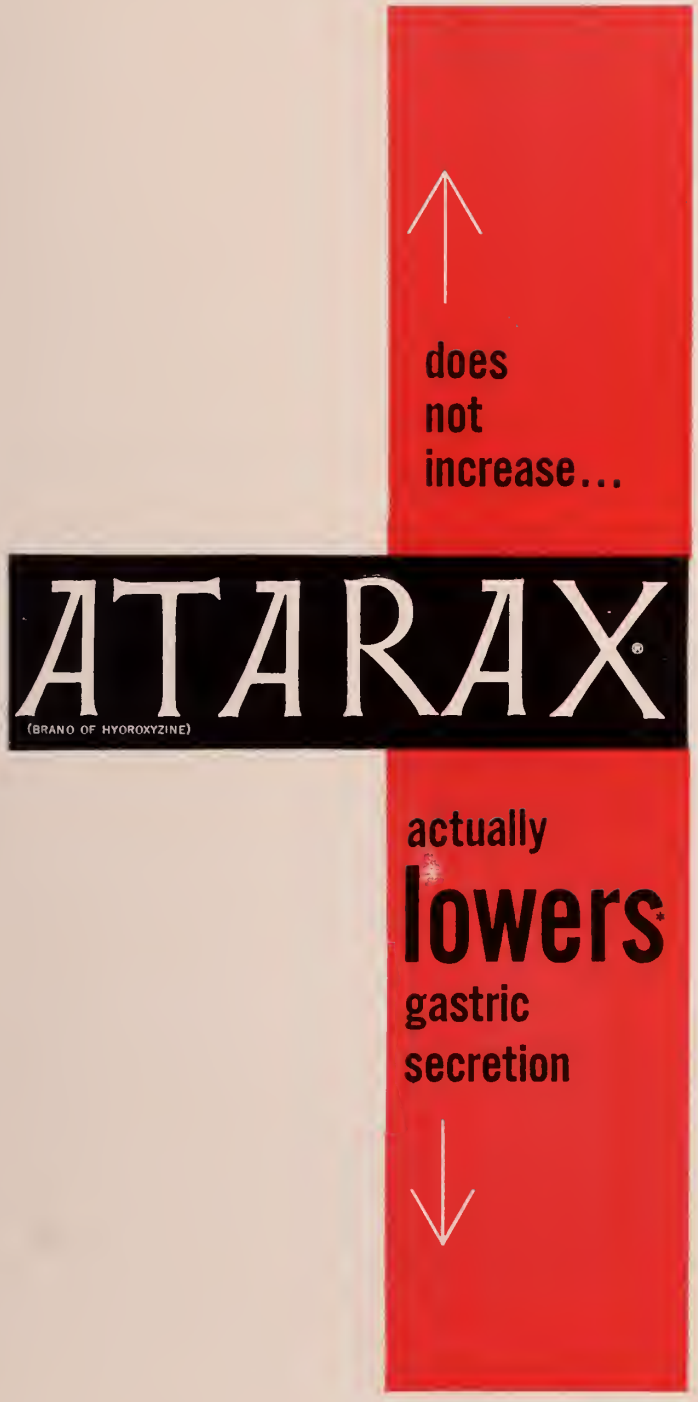
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25¢ Bottle of 48 tablets (1¼ grs. each).

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Now you have 4 advantages when you calm ulcer patients with ATARAX:

1. ATARAX suppresses gastric secretions; others commonly increase acidity.
2. ATARAX is "the safest of the mild tranquilizers."[2] (No parkinsonian effect or blood dyscrasias ever reported.)
3. It is effective in 9 of every 10 tense and anxious patients.
4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.



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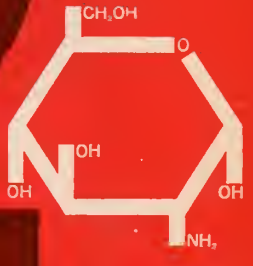
The Medical Society of New Jersey

Place	Name and Address	Telephone
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The most widely prescribed broad-spectrum antibiotic now potentiated with glucosamine, the enhancing agent of choice

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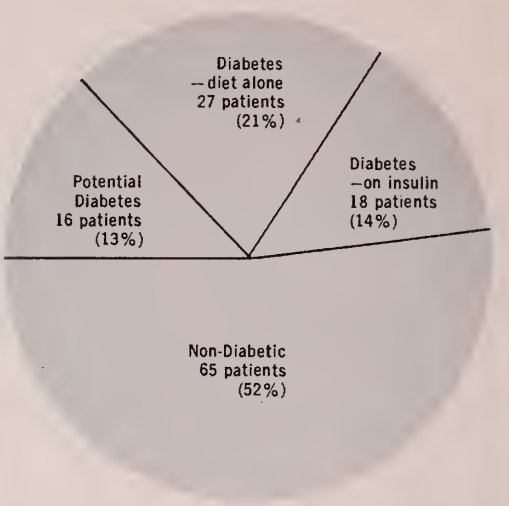
Capsules, 250 mg., 125 mg.
Half strength (125 mg. capsules) for long-term indications or pediatric use.

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*Murphy, R.: Connecticut M. J. *21*:306, 1957.

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the STANDARDIZED urine-sugar test
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STOP respiratory congestion orally

relief in minutes..lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes.* Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

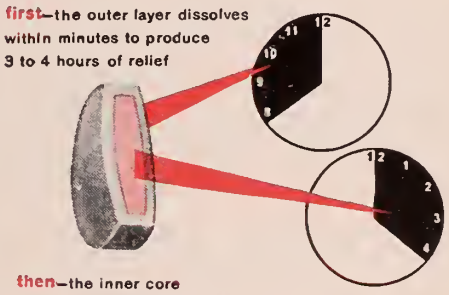
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each double-dose "timed-release" TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pyrilamine maleate	25 mg.
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Dosage: 1 tablet in the morning, afternoon, and in the evening if needed.

Each double-dose "timed-release" tablet keeps nasal passages clear for 6 to 8 hours— provides "around-the-clock" freedom from congestion on just three tablets a day



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STOP *running noses...* *and open stuffed noses orally*

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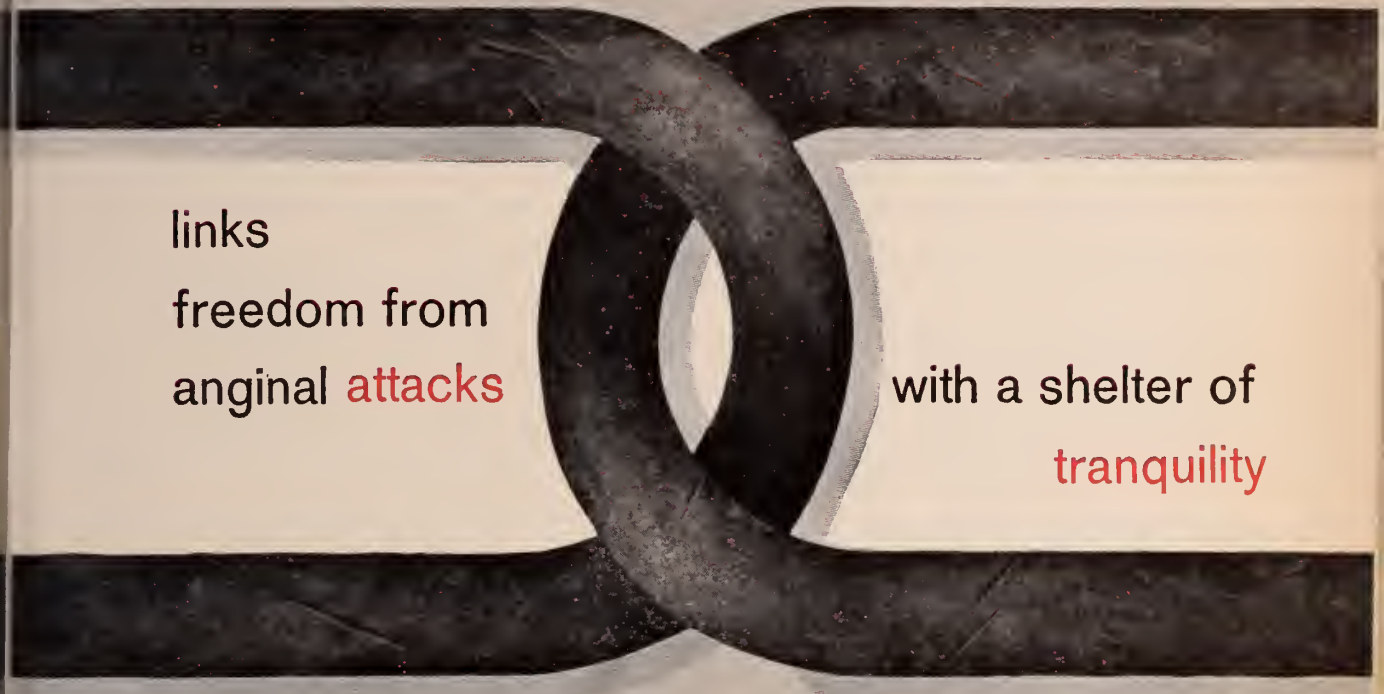
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CARTRAX*



links
freedom from
anginal attacks

with a shelter of
tranquility

In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inexorably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100. CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

*TRADEMARK

Roerig

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

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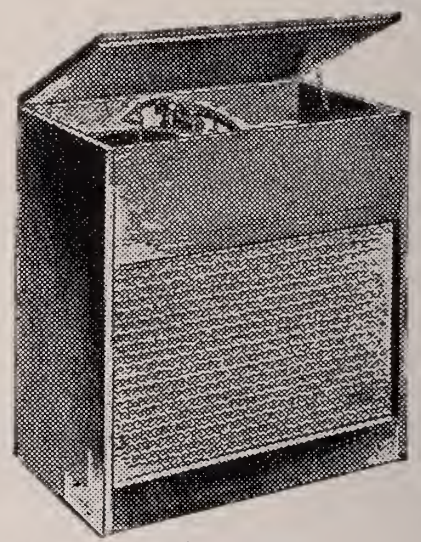
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anti-inflammatory effects
with lower dosage
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a new low in the collateral
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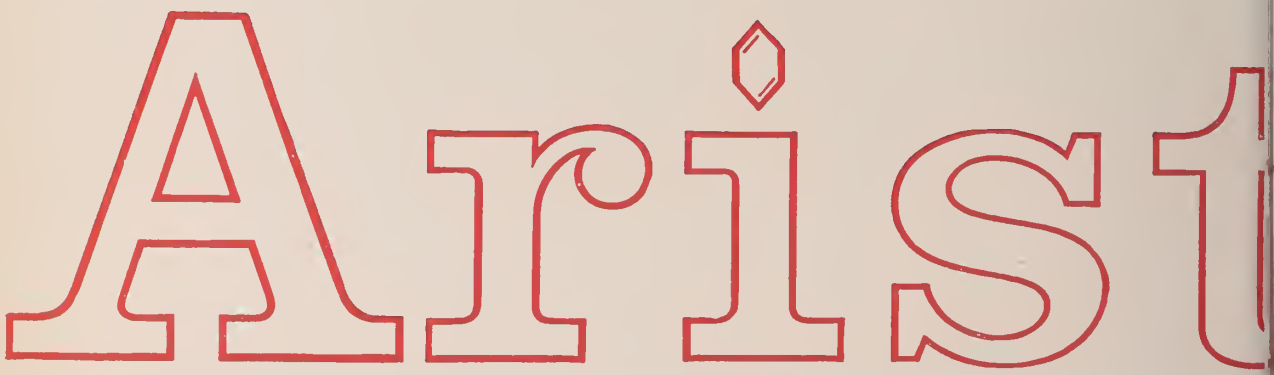
- No sodium or water retention
- No potassium loss
- No interference with psychic equilibrium
- Low incidence of peptic ulcer and osteoporos

Aristocort is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 1

Lederle

The Achievement in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone.[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]... absence of serious side effects specifically noted.[1,2,3]

The Achievement in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]...6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]



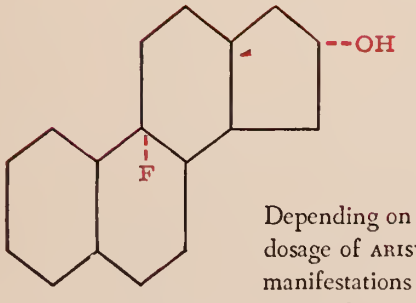
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2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
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8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
9. Ibid.: Personal Communication.
10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

The Achievement in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

The Achievement in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]

ocort®

Triamcinolone LEDERLE



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER NEW YORK

in cases of tension

Serpate®

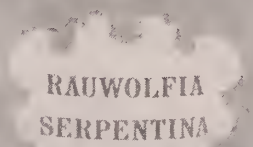
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. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedotion without hypnosis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies



in cases of hypertension

Rauval®

(Rauwolfia Serpentina, Vale)

. . . double assayed to insure optimal therapeutic effect
tested chemically to insure total alkaloid content
tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

. . . achieves gradual lowering of the blood pressure, gentle sedation, tranquilization with prolonged effect even after cessation of therapy

supplied: 50 mg. and 100 mg. tablets in bottles of 100 and 1000, or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*
PHARMACEUTICALS

in common mixed infections
...tetracycline phosphate alone

PANMYCIN* Phosphate

for children:

PANMYCIN KM Syrup

TRADEMARK

BROAD-SPECTRUM TETRACYCLINE IN ITS MOST EFFICIENT FORM

Produces more tetracycline in the blood with no more in the dose. No calcium to depress blood levels.[1] Basic broad-spectrum therapy in bronchitis, pharyngitis, otitis media, tonsillitis, and other common respiratory infections.

1. Welch, H., Wright, W. W. and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 4:620, 1957.

in potentially serious infections
...tetracycline phosphate plus novobiocin

PANALBA*

for children:

PANALBA KM Granules

TRADEMARK

THE BREADTH OF PANMYCIN PHOSPHATE PLUS THE ANTIMICROCOCCAL DEPTH OF ALBAMYCIN†

Offers maximum antimicrobial action at the earliest possible moment. The antibiotic preparation of first resort in pneumonia of unknown etiology, carbuncles, multiple furunculosis, cellulitis, and infections resistant to previous therapy.

†TRADEMARK REG. U. S. PAT. OFF. — THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

for the 7 monilia-susceptible types
...tetracycline phosphate plus nystatin

COMYCIN*

PANMYCIN PHOSPHATE PLUS THE ANTIMONILIAL PROTECTION OF NYSTATIN

The logical choice for patients requiring high doses of antibiotics or prolonged antibiotic therapy, for patients with previous monilial complications, for diabetics, patients on cortical colds, the pregnant, debilitated, or elderly, and for infants, especially the premature.

Upjohn

The Upjohn Company, Kalamazoo, Michigan



THE CHOICE OF A SYSTEMIC ANTIBIOTIC IS A MATTER OF CLINICAL JUDGMENT

1. PANMYCIN PHOSPHATE IN COMMON MIXED INFECTIONS

USUAL DOSAGE: ADULTS: 250 mg. every 6 hours or 500 mg. every 12 hours. CHILDREN Approximately 8 mg. per pound of body weight daily, in four equally divided doses every 6 hours, or two equally divided doses every 12 hours.

SUPPLIED: CAPSULES: 250 mg. in bottles of 16 and 100; 125 mg. in bottles of 25 and 100.

PANMYCIN KM SYRUP: Each teaspoonful (5 cc.) contains tetracycline equivalent to 125 mg. tetracycline hydrochloride, and potassium metaphosphate, 100 mg., mint flavor, in 2 fluidounce and pint bottles.

2. PANALBA IN POTENTIALLY SERIOUS INFECTIONS

USUAL DOSAGE: ADULTS. 1 or 2 capsules three or four times a day, depending on the type and severity of the infection. CHILDREN: Proportionately less.

SUPPLIED: Each powder-blue-and-brown capsule contains Panmycin (tetracycline) Phosphate complex equivalent to 250 mg. tetracycline hydrochloride, and Albamycin (as novobiocin sodium) 125 mg.; in bottles of 16 and 100.

Also available: **PANALBA KM GRANULES** (Pediatric). When reconstituted, each 5 cc. teaspoonful contains Panmycin equivalent to tetracycline hydrochloride, 125 mg. and Albamycin (as novobiocin calcium) 62.5 mg., and potassium metaphosphate 100 mg.; in pleasantly flavored vehicle. Dosage is based upon amount of tetracycline—6 to 8 mg. per pound of body weight per day in 2 to 4 equally divided doses.

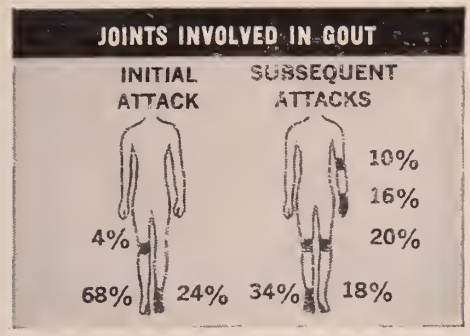
3. COMYCIN FOR THE 7 MONILIA-SUSCEPTIBLE TYPES

USUAL DOSAGE: ADULTS. 1 or 2 capsules every 6 hours. CHILDREN Proportionately less.

SUPPLIED: Each brown-and-pink capsule contains tetracycline phosphate complex, equivalent to 250 mg. tetracycline hydrochloride; nystatin 250,000 units. In bottles of 16 and 100.

Upjohn

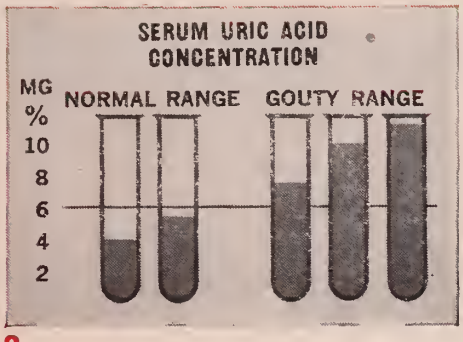
The Upjohn Company, Kalamazoo, Michigan



1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

FROM THESE FINDINGS...SUSPECT GOUT:

℞ BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

Once findings point to gout, long-term management can be started with BENEMID. This effective uricosuric agent has these unique benefits:

- Urinary excretion of uric acid is approximately doubled.
- Serum uric acid levels are reduced.
- Uric acid deposits (tophi) in tissues are mobilized.
- Formation of new tophi can often be prevented.
- Fewer attacks and severity is reduced.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID is a trade-mark of Merck & Co., Inc.

MSD

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DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.



when your patients tell you: "I can't sleep," your reliable, conservative answer is

NOCTEC

Squibb Chloral Hydrate

NOCTEC

GENERAL PRACTICE "The general practitioner likes it... can be given to patients of all ages and physical status"

CARDIOLOGY "patients with cardiac disease... no proof that it is deleterious to the heart"

DERMATOLOGY "frequently the favorite of the dermatologist... skin reactions from it are uncommon"

PSYCHIATRY "The psychiatrist often finds it the agent of choice... much less likely to produce mental excitement" Current Concepts in Therapy: Sedative-Hypnotic Drugs II. Chloral Hydrate. New England J. Med. 255: 706 (Oct. 11) 1956.

Adults: 1 or 2 7½ gr. capsules or 1 or 2 teaspoonfuls of Noctec Solution 15 to 30 minutes before bedtime.

Children: 1 or 2 3¾ gr. capsules or ¼ to 1 teaspoonful of Noctec Solution 15 to 30 minutes before bedtime.

Supply: 7½ and 3¾ gr. capsules, bottles of 100. Solution, 7½ gr. per 5 cc. teaspoonful, bottles of 1 pint.

*NOCTEC ® IS A SQUIBB TRADEMARK.

SQUIBB *Squibb Quality—the Priceless Ingredient*



TAKE A NEW LOOK AT ALLERGENS*
TAKE A LOOK AT NEW DĪMETANE

There is no antihistamine better than DIMETANE for allergic protection. DIMETANE gives you good reasons to re-examine the antihistamine you are now using: unexcelled potency, unsurpassed therapeutic index and relative safety...minimum drowsiness or other side effects. Has been effective where other antihistamines have failed. DIMETANE Extentabs® (12 mg.) protect for 10-12 hours on one tablet. Also available: Tablets (4 mg.), Elixir (2 mg. per 5 cc.).

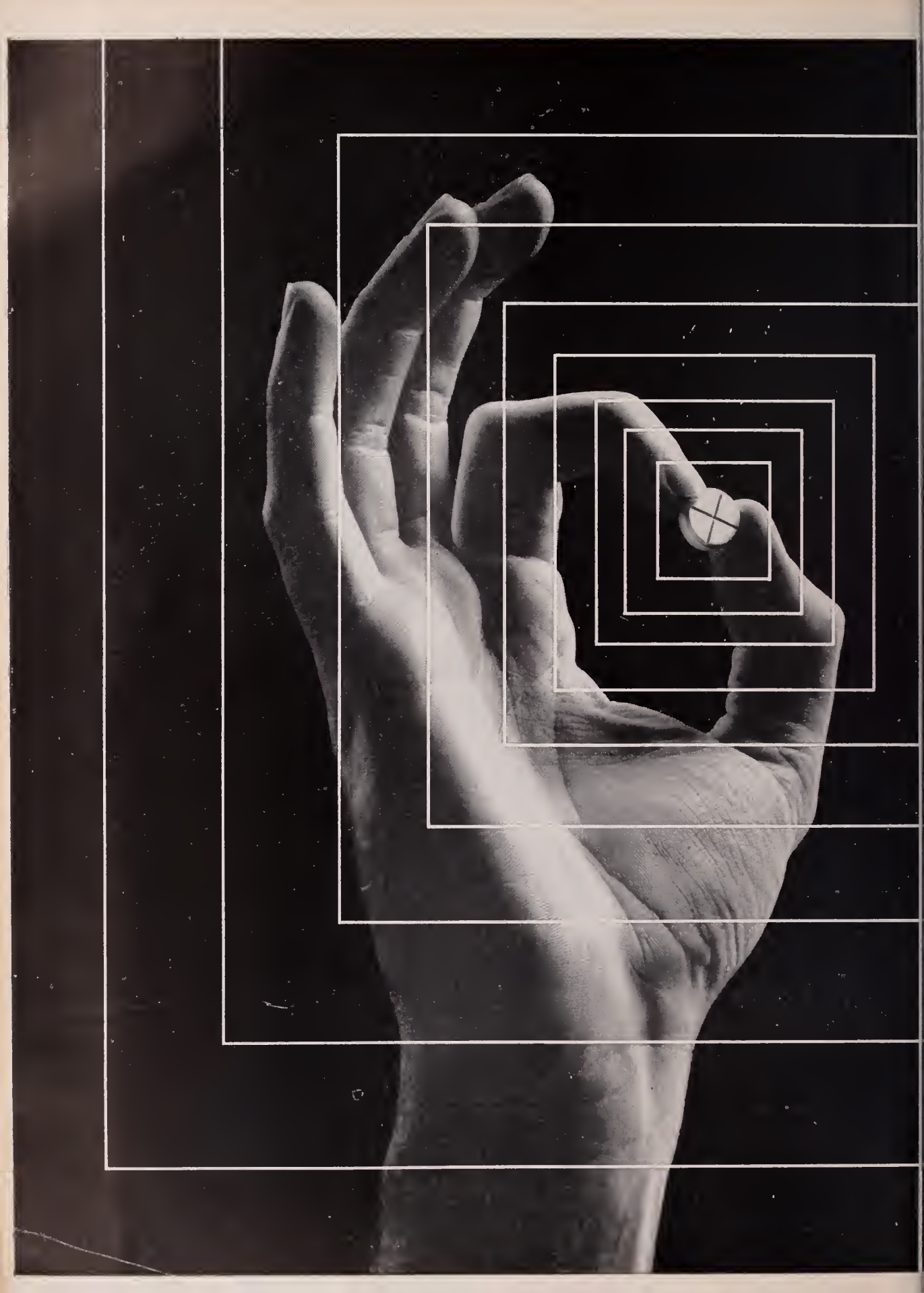
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(PARABROMDYLAMINE MALEATE)

Dīmetane®



a new era

in sulfa therapy

ONLY ONE TABLET A DAY

KYNEX*

SULFAMETHOXYPYRIDAZINE (3-SULFANILAMIDO 6-METHOXYPYRIDAZINE) LEDERLE

New authoritative studies prove that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

- Lowest Oral Dose In Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
- Higher Solubility—effective blood concentrations within an hour or two
- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*Reg. U. S. Pat. Off.



How to provide unsaturated fatty acids without dieting

With type as well as amount of fat in the human diet now assuming such importance, the new role of corn oil as a source of unsaturated fatty acids has prompted these questions:

1 What is the role of unsaturated fats in the daily diet?

answer: There is now ample clinical evidence that unsaturated fats tend to lower the serum cholesterol level of human subjects, whereas saturated fats have the opposite effect.

2 How much of the important unsaturated fatty acids does corn oil provide?

answer: MAZOLA Corn Oil yields an average of 85 per cent unsaturated fatty acids. 100 grams of MAZOLA will yield: 53 grams of linoleic acid and 28 grams of oleic acid; it also provides 1.5 grams of sitosterols, and only 12 grams of saturated fatty acids.

3 What is the best way to provide unsaturated fatty acids?

answer: By balancing the types of fat in the daily diet. Many doctors now agree that from one third to one half of the total fat intake should be in the form of a vegetable oil such as corn oil (MAZOLA).

4 How is corn oil most easily taken in the usual daily diet?

answer: There is no need to disturb the daily routine of meals or to have separate diets for individual members of the family. MAZOLA Corn Oil can be used instead of solid fats in preparing and cooking foods, it is also ideal for salad dressings.

5 How can I obtain further information on the value of corn oil as a source of unsaturated fatty acids?

answer: The subject is reviewed in the book "Vegetable Oils in Nutrition." Also available is a recipe book for distribution to your patients. It tells how to use corn oil in everyday meals. Both books will be sent free of charge to physicians, on request.

CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N.Y.



How Old is Too Old for Tranquilizers ?

The psychological needs of the elderly confront physicians with one of their most perplexing problems. Perhaps no other patient group suffers so much from emotional distress. Yet, precisely because of their age, geriatric patients often seem beyond the reach of tranquilizing treatment.

When tranquilization seems risky . . .

They are too much beset by complicating chronic ailments, too susceptible to serious side effects. Ataraxia is clearly indicated, yet the doctor cannot risk side reactions on liver, blood or nervous system.

Is there an answer to this dilemma?

We feel there is. In four recent papers investigators have reported good results with ATARAX in patients up to 90 years of age.* In one study, **improvement was "pronounced" in 76%, "good" in an additional 18.5%.*** ATARAX has been successfully used in such cases as senile anxiety, agitation, hyperemotivity and persecution complex.* On ATARAX, patients became ". . . quieter and more manageable. They slept better and demonstrated improved relations with other patients and hospital personnel. Even their personal hygiene improved, and they required less supervisory management."*

. . . ATARAX is safe

Yet even in the aged, ATARAX has given "no evidence of toxicity. . . . Complete liver function tests and blood studies were made on all patients after two months of therapy. . . . There were no significant abnormalities."* With still other elderly patients "tolerance to the drug was excellent, even in cases where the patients were given relatively high doses."* Similarly, no parkinsonian effects have been observed on ATARAX therapy.

Nor does ATARAX make your patients want to sleep all day. Instead, they can better take care of themselves, because ATARAX leaves them both calm and alert. In sum, ATARAX ". . . does not impair psychic function and has a minimum of side effects. . . . It appears that ATARAX is a safe drug. . . ."*

These, undoubtedly, are the results you want when emotional problems beset your geriatric patients. For the next four weeks, won't you prescribe tiny ATARAX tablets or pleasant-tasting ATARAX syrup — both so readily acceptable to the elderly.

*Documentation on request

ATARAX®
(BRAND OF HYDROXYZINE)

M. A. Seidel M.D.
Medical Director

ATARAX
in any hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.



New York 17, New York
Division, Chas. Pfizer & Co., Inc.

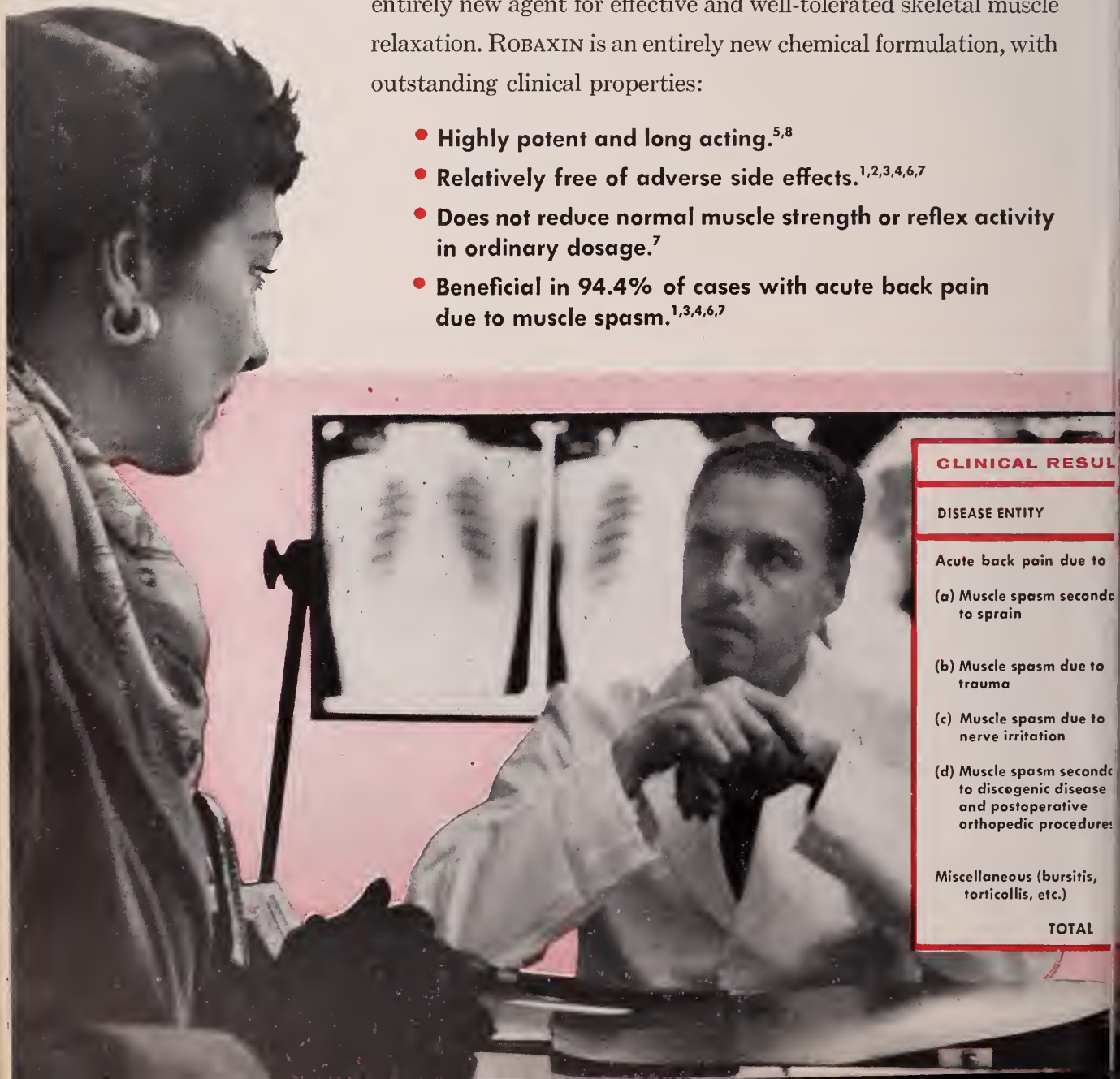
Significant Robins research discovery:

A NEW SKELETAL MUSCLE RELAXANT

Ro

ROBAXIN – synthesized in the Robins Research Laboratories, and intensively studied for five years – introduces to the physician an entirely new agent for effective and well-tolerated skeletal muscle relaxation. ROBAXIN is an entirely new chemical formulation, with outstanding clinical properties:

- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RESUL	
DISEASE ENTITY	
Acute back pain due to	
(a) Muscle spasm seconde to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm seconde to discogenic disease and postoperative orthopedic procedure:	
Miscellaneous (bursitis, torticollis, etc.)	
TOTAL	



baxin®

(Methocarbamol Robins, U.S. Pat. No. 2770649)

Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

ITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

. OF SES	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
3	2-42 days	3-6 Gm.	17	1	0	0	None, 15 Dizziness, 1 Slight nausea, 1
3	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
5	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
1	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
6	3-60 days	4-8 Gm.	6	0	0	0	None, 6
2			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

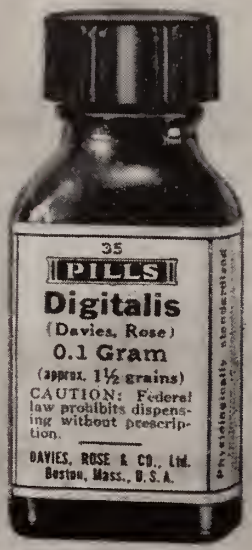
Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

Supply – Robaxin Tablets, 0.5 Gm., in bottles of 50.

A. H. ROBINS CO., INC., Richmond 20, Va.

Digitalis

in its completeness



Each pill is
equivalent to
one USP Digitalis Unit

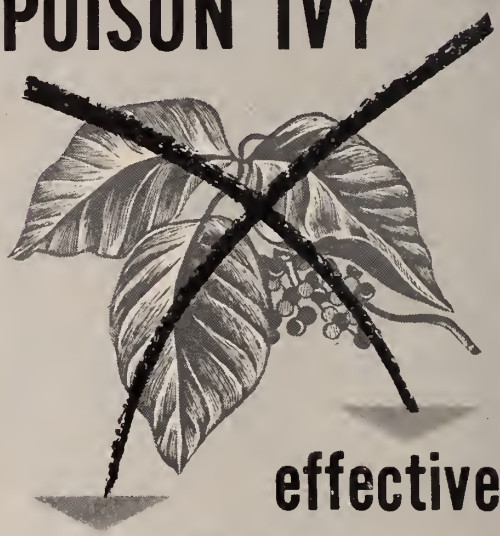
Physiologically Standardized
therefore always
dependable.

Clinical samples sent to physicians upon request.

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Boston, 18, Mass.

AQUA IVY, AP®

a new approach to POISON IVY



effective prophylaxis

93% EXCELLENT TO GOOD RESULTS

AQUA IVY, AP®—the poison ivy and poison oak desensitizer, developed by Strauss and Spain, is the whole pyridine extract of poison ivy leaves which is alum precipitated to form an insoluble complex that is readily suspended in normal saline for injection. This results in immunity and prevents the severe reactions often seen from the prophylactic use of ordinary poison ivy extracts.

AQUA IVY, AP®, is administered subcutaneously with little or no pain, and without the usual reaction at the site of injection. That's why it is so.....

*** EFFECTIVE * NON-IRRITATING**
*** LONG ACTING * INEXPENSIVE**

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Literature Available—Please Write Dept. H.



If Monilial overgrowth is a factor

Achrostatin* V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

Combines ACHROMYCIN V with NYSTATIN

SUPPLIED:

CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

ACHROSTATIN V combines ACHROMYCIN† V ... the new rapid-acting oral form of ACHROMYCIN† Tetracycline ... noted for its outstanding effectiveness against more than 50 different infections ... and NYSTATIN ... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

*Trademark †Reg. U. S. Pat. Off.

Lederle

ELIEF

1



2



FROM INFECTION*

FROM IRRITATION

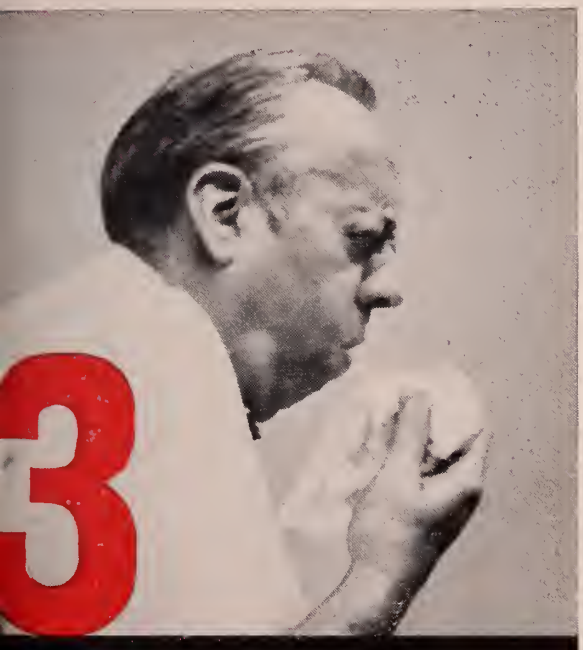
*as adjunctive therapy only

THE FIRST TROCHE TO PROVIDE THREEFOLD BENEFITS

'PENTAZETS'

TROCHES

NON-NARCOTIC ANTITUSSIVE EFFICACY SHOWN TO APPROXIMATE THAT OF CODEINE



AND **NOW** COUGH CONTROL TOO

With the addition of a non-narcotic antitussive to troche medication, 'PENTAZETS' provides a new and extended therapeutic advantage in this convenient form of treatment.

Treatment of the cough too, so often a troublesome symptom of sore throat, combined with wide-range antibiotic activity and soothing analgesic benefit, now offers *three*fold relief in a variety of throat irritations.

And 'PENTAZETS' are pleasant-tasting, too, making them highly acceptable, especially to children.

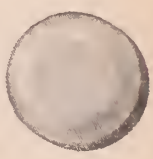
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'Darvon'	*32 mg.*
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Rx: M. D.

"Give something of yourself" is the plea made by the Old Professor at the medical school graduation. It is as if the doctor himself were a kind of therapeutic potion given to the patient in smaller or larger dose. An intriguing idea, with endless possibilities. The psychotherapist who already measures his patient contacts in time seems to work on this principle—for some patients get a 50 minute amount of "Rx-M.D." and some get a 15 minute dose! But the psychiatrist has no monopoly of administering the doctor as therapy, although he seems to be the only physician who doles it out that frankly. In every physician-patient contact, the doctor himself is a therapeutic tool, given in greater or lesser potency, with greater or lesser skill.

It is a medication with the possibility of some strange side-effects. Every M.D. is aware of the way in which his personal reactions may hurt the patient—the implication of the brush-off, the edgy voice of impatience, the mellow acceptance of good humor. It is, furthermore, a drug that can be given in overdose — too much doctor, too much personal attention. More often it is given in inadequate dosage: not enough doctor, too much attention by the ancillary personnel. And then there are the iatrogenic illnesses, clear-cut cases of untoward effects.

How tediously we toil over the pharmacology of the natural and synthetic drugs, how little we study the pharmacology of the drug "physician." There is a standard breakdown for pharmacology: origin of the drug; its composition; its effect on physiology; dosage; fate in body; untoward effects, sensitivity and hypersensitivity; effects of overdosage; antidotes.

Here is a course needed in all medical schools, taught in none. What are the components of this drug—how is it put together? How does hostility in the physician affect the patient's blood-pressure, gastric secretions, muscle tonus? What is the effect of good cheer in the doctor—or of indifference, of anger, of affection, of interest or of haste?

Some patients have been sensitized to the drug by previous bad experiences. How to test

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for this sensitivity and how to desensitize the patient? And, if ill-effects are produced by bad administration of this strange potion, what then is the antidote?

Pope's line about the "proper study of mankind" might be paraphrased:

"Oh first return your textbooks to the shelf;
And start your study doctor, with yourself!"

Not a very heroic couplet, to be sure, but still a truth. More truth, indeed, than poetry.

Is Blue Shield a Third Party?

One of the precious elements of the physician-patient relationship is the fact that no third party intervenes. In many insurance and governmental medical care programs, some person or agent does come between doctor and patient.

Is Blue Shield a "third party" in this sense? No. Blue Shield is an organization of the profession itself, and not a third party between doctor and patient.

The medical profession, through its own instrument, Blue Shield, pioneered the uncharted realm of medical prepayment at a time when commercial insurance companies declared it was actuarially impossible.

What is a "third party between doctor and patient"? In simplest terms, a "third party" must be some person or agency over whom neither the first party—the patient—nor the second party—the doctor—has any direct control; someone independent of both.

The first requirement of a medical prepayment plan that wants to call itself Blue Shield is that it be approved by the county or state society in the area that it serves. The second requirement is that all medical policies and operations be under medical control; and the third, that it earn the voluntary participation of at least a majority of the doctors in its territory.

Blue Shield is not a "third party." Blue Shield has proved that doctors and patients, working together, can solve the problems of medical economics without needing any third party to come between them.

The Underprivileged Male

In terms of longevity males seem to be an underprivileged segment of the population. Not only do women live longer than men, but the gap is getting greater. Last year the death rate for males was 50 per cent higher than that for females.

This is due in part to medical progress. In primitive countries women have a higher death rate because of the dangers of childbirth. In countries like ours, where the obstetrical hazards are minimized, men consistently have a higher death rate. Cancer is about one-fifth more common as a cause of death in men than women in spite of the frequency of cancer of of the breast and uterus. It seems that malignancies of the pulmonary, gastro-intestinal and genito-urinary tracts are more common or more rapidly fatal. Accidents, of course are more common among men than among women.

Whatever the cause, the fact is that women live longer. In spite of the fact that they live longer they appear to have more illnesses. This statistic is derived from reports of clinics, doctors and hospitals. It may mean merely that women are more willing to consult a doctor when they feel sick.

This last item might suggest that one reason for the male's unfavorable position here is his own unwillingness to seek medical attention in good time. The "See your doctor twice a year" advice has some real meaning after all. Physicians might follow it too.

Alfred R. Henderson, M.D.
Harvey Black
Robert R. Meijer, Ph.D
Michael Maloney
H. Hakim, M.D.
Asbury Park

The Mechanical Heart*

ITS MECHANISM AND CLINICAL APPLICATION

"If the conquests useful to humanity touch your heart . . . then, I implore you, take some interest in the sacred dwellings meaningfully described as laboratories. They are the temples of the future . . . There humanity grows better, stronger, greater . . ."—Louis Pasteur.

Paramount among achievements of medical science within the past decade has been the eradication of prohibitive barriers to direct visual repair of intracardiac anomalies. The closed, blind approaches to a few of these lesions left much to be desired. Only an open, dry organ would permit direct, accurate surgical repair. The development of the mechanical pump-oxygenator, permitting cardiac and pulmonary by-pass, has made this an established, practical fact.

It is obligatory that a mechanical pump-oxygenator of any design meet certain basic requirements without compromise. These are:

1. Cause the least possible injury to the formed elements of the blood.
2. Circulate an adequate and varying blood volume safely;
3. Will not promote alterations in the clotting mechanism;
4. Sufficiently oxygenate the blood;
5. Permit freedom of carbon dioxide release; and
6. Not allow deliverance of free gas or other emboli.

To this generally accepted list might well be added another desirable feature: simplicity and ease of utility. It is a sign of scientific immaturity that many of the existing machines are over-burdened with monitoring electronics, safety gauges, control and precautionary devices. One cannot help but reflect upon the earliest models of the electrocardiograph and the radio . . . knowing full well that eventually, as experience and confidence grow, simplicity will replace intrication. Complex machinery sometimes reflects anxiety existing as a side symptom of ignorance and impatience over the wide gaps in our basic knowledge.

THE PUMP

Various methods of moving the blood stream extracorporeally have been employed successfully. Factors other than the propelling

*From the Cardiovascular Surgical Research Laboratory, Monmouth Memorial Hospital, Long Branch, N. J.

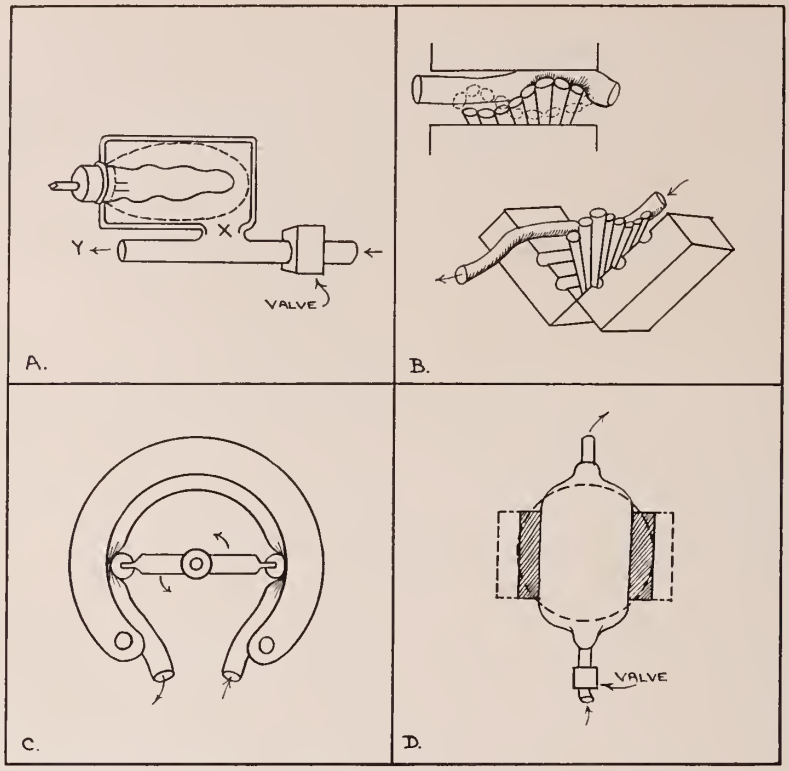


Figure 1. Various types of pumping principles. (Explanation in text)

device have been more responsible for hemolysis (*e.g.* method of oxygenating, tubing connectors, construction materials). Four varieties of pumping principles are illustrated in Figure 1.

Diagram A (Fig. 1) represents an inflatable cot within a small cylinder. Alternately inflating and deflating the cot withdraws blood into the chamber (X) and expels it via outlet (Y).[1]

(B) is often referred to as the multiple-fingered massage pump (Sigmamotor). A series of metallic fingers alternately compress and release the plastic tubing in a unidirectional manner, causing the contained blood to be pushed forward.[2]

(C) affords tube compression in a unidirectional manner by rollers located at the extremities of a rotating arm.[3,4,5]

(D) represents external compression of another variety. Essentially the rubber bulb syringe principle is employed where a large, soft tube or compressible bulb is squeezed on two sides. Valves are required to maintain unidirectional flow.[6]

Essentially, most pump-oxygenators in use today consist of four distinct parts: a venous pump, coronary sinus aspirating unit, oxygenator and arterial pump. Figure 2 diagrammatically illustrates the basic pattern.

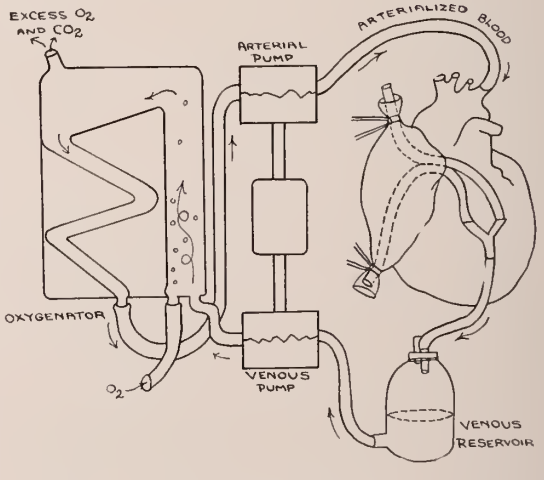


Figure 2. Scheme of extracorporeal circulation and oxygenation. Figure 5 shows actual physical relationships of pump-oxygenator.

Some have eliminated the venous pump in favor of gravity drainage from the caval system. However, a pump will still be necessary to transport the venous blood from the collecting reservoir to the oxygenator. The following series of events occurs in the routine open

heart operation regardless of individual differences in pumping and oxygenating devices:

Cannulae are placed in the vena cava through the right atrial wall (appendage). Tight temporary ties about the vena cavae prevent the returning venous blood from entering any place but into the cannulating tubes. The venous blood is thus siphoned from the circulatory system into the pump-oxygenator where oxygenation takes place and carbon dioxide is automatically eliminated. From the "artificial lung" the blood is then pumped by the arterial pump back into the circulatory system through a cannula placed in the subclavian or femoral artery.

Venous blood returning to the heart through routes other than the vena cavae (coronary sinus, Thebesian veins, retrograde pulmonary arterial flow from bronchial arterial collaterals, and so forth) is sucked into the venous extracorporeal system by an auxiliary pump. It is important to recover this blood from the operative field since it can represent as much as 20 per cent of the total circulatory volume; its loss into the chest cavity is significant.

Normally, the semilunar valves completely seal the aortic orifice by virtue of the perfusion pressure from above. This pressure is also responsible for continuous coronary perfusion. However, incompetent or displaced valves can account for considerable back flow through a ventricular septal defect and pose momentous problems in maintaining comparable venous-arterial flow rates outside the body.

FLOW RATES

How much blood must be perfused to maintain life during open heart surgery? There is some divergence of opinon. Basal life can be maintained satisfactorily for one to two hours at output rates about one-half the textbook figures. The low flow rates referred to as the "azygos flow principle" (about 10 per cent normal output), initially described as capable of sustaining the life of animals under basal conditions are a little misleading from the practical point of view.[7] There is sometimes a broad gap between sleeping dogs with a normal cardiovascular system and the diseased patient. Original flow rates of 40 to 55 cubic centimeters per kilogram per minute have been elevated gradually, with increasing success, both in the laboratory and operating room. Perfusion rates of 70 to 700 cubic centimeters per kilogram per minute seem more satisfactory.

The amount of blood perfused over a given time is only part of the picture of adequate circulating volume. How much is not enough . . . under what pressure perfusion is carried out determines even more how well supplied with blood will be the vital centers. We have found that experimental survival rates drop markedly when arterial perfusion drops below 60 millimeters (mercury). An attempt is always made to maintain aortic arch pressures well above 70. The brain is not supplied adequately; the coronaries are not perfused sufficiently; flow through the kidneys is sluggish and there is a marked tendency to visceral pooling, when aortic pressures drop below 60. In turn, this leads to poor vena caval filling and venous return to the pump drops dangerously.

TEMPERATURE REGULATION

With large quantities of blood circulating outside the body, thereby being exposed to the cooling effects of room temperature and bubbling oxygen, there is a gradual decline in blood temperature. Without a warming device, there is an average drop of 4 to 6 degrees Fahrenheit during a 30 minute perfusion. Some feel that this is perfectly safe; indeed, a few investigators suggest that some degree of refrigeration (total body) is also in order. However, it is our opinion that to superimpose total body refrigeration upon a method designed to rid us of the effects of this deep cooling technic is to court unnecessary problems and dangers. The nearer we can approximate normal bodily conditions, the safer we feel. For this reason, a special blood-warming apparatus was designed to maintain body temperatures as closely as possible. (Fig. 5, T). Such a warming device must possess the all-important property of rapidly varying

its heat output with slightest alterations of blood flow. Sudden slowing of the moving stream would otherwise result in intolerable "cooking" of the blood.

INDUCED ASYSTOLE

THE feasibility of correcting intracardiac defects by the direct vision technic has been increased by the purposeful production of cardiac arrest (asystole). A stilled, limp heart has obvious advantages, from the operator's viewpoint, over a jumping, irritable one. Elective cardiac asystole can be produced in a number of ways with assurance of a return of the beat within a reasonable length of time.[8,12] Intracoronary instillation of potassium citrate, potassium chloride, acetylcholine or simple cross-clamping of the coronary arteries (myocardial hypoxic arrest) will produce an abrupt arrest of the heart beat for as long as the surgeon desires with spontaneous recovery almost always following. That little word, "almost" has resulted in a certain amount of conservatism in some men who refrain from the added comforts of a quiet heart in cases where low cardiac reserve and cyanosis find no comparisons in the experimental laboratory.[13]

THE OXYGENATOR

NORMALLY, only 0.7 of a second is required for oxygenation of hemoglobin and elimination of carbon dioxide. This rapid physiologic feat makes it possible to oxygenate a large volume of blood moving at high velocity with but a few major difficulties. The speeding stream must be debubbled completely of free gas before returning to the arterial pump and it must be afforded ample opportunity to rid itself of carbon dioxide. The process must be accomplished with a minimum of hemolysis. Numerous methods of oxygenating blood extracorporeally have been fathomed. Two fundamental systems exist: (1) the dispersal of blood in an oxygen medium; (2) dispersal of oxygen in blood. Figure 3 illustrates some of the methods of blood dispersal within an oxygen medium.

Several methods of dispersing oxygen in blood are illustrated in Figure 4.

A brief discussion of other methods used to deliver arterialized blood to the patient is in order. In one, arterial blood was pumped directly into the patient's subclavian artery from a compatible donor; simultaneously, his venous (vena caval) blood was shunted into a large vein of the donor.[21] This reciprocal transfer of blood is controlled accurately by a double pump located between the patient and the donor ("controlled cross-circulation").

Another "biological oxygenator" system involved the use of a dog or monkey's lung.[6,22] In place of one of the film or bubble systems, the animal lung, after meticulous clearing of all heterogenous blood elements, was used as a perfusion and oxygenating medium. Rhythmic inflation and deflation of the lung was accomplished with oxygen through the cannulated trachea after removal from the freshly killed animal. The retained pulmonary arteries and veins were used to conduct the patient's blood through the natural oxygenating system.

An even simpler technic was found applicable in small infants requiring low flow rates and pressures. Perfusion was accomplished by simply suspending a bottled reservoir of oxygenated blood above the heart, allowing gravity-flow to perfuse the aorta. Vena caval return flow was withdrawn into a flask and not returned to the patient.[23] Though originally thought satisfactory for infants, the "gravity-feed" method of aortic perfusion has been revived recently as possibly applicable to larger patients.[24]

THE PROBLEM OF HEMOLYSIS

OF ALL body fluids, blood is the most friable.

To divert the entire circulatory stream into an artificial, man-made extracorporeal circuit, and to develop mechanical substitution for the ventilatory apparatus and function, is to assume a grave responsibility. This becomes even more serious when one ponders the altered physiology associated with an anomalous

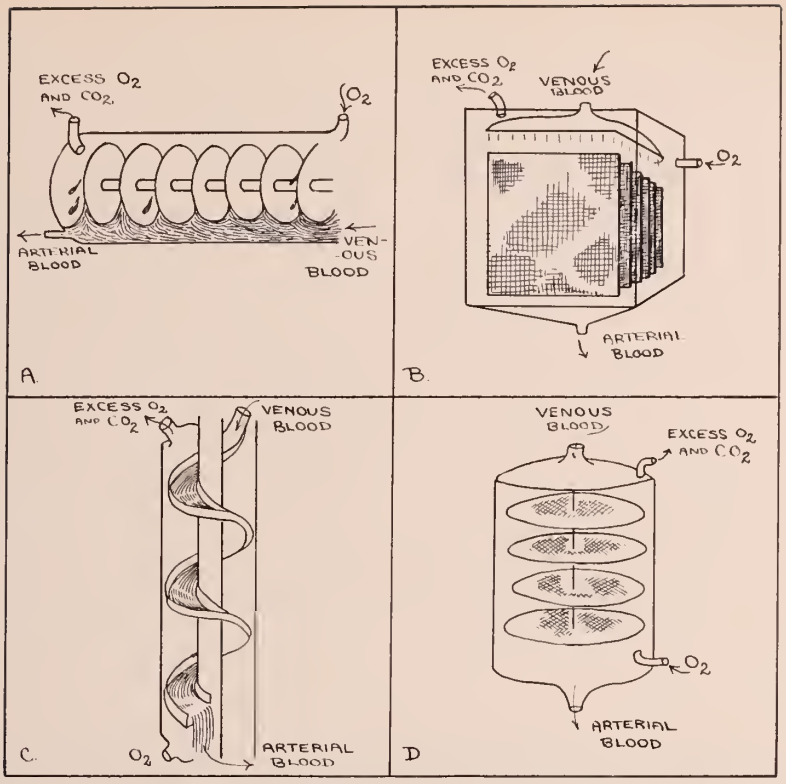


Figure 3. Types of oxygenators using principle of dispersion of blood in oxygen atmosphere.

A. Rotating disc oxygenator. Spinning discs dip into a moving pool of blood. Film formed on disc is exposed to oxygen atmosphere.[14] The discs are either solid or made of wire mesh screen.[15]

B. Series of vertical screens over which blood flows within an oxygen medium, collecting by gravity at the base.[5]

C. Spiral descent in an oxygen atmosphere.[16]

D. Series of compressed screens. Blood flows through mesh downward; oxygen ascends under pressure.[17]

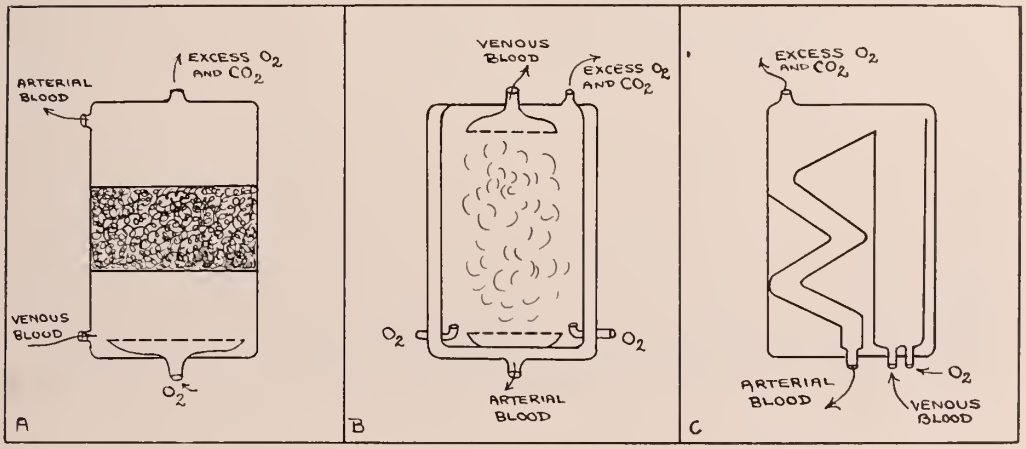


Figure 4. Types of oxygenators using principle of dispersion of oxygen in blood.

A. Dispersion of minute bubbles of oxygen throughout incoming venous stream. An internal coating with antifoaming agent and a debubblizing mechanism is required before returning blood to arterial pump.[18,19]

B. Blood descends against an upward jet of oxygen (foam-oxygenator). Debubbling is more of a problem here than with other types of bubblators.[19]

C. Bubble-oxygenator principle of DeWall employed in the mechanical heart herein reported (Fig. 0).[20]

cardiovascular structure to be dealt with surgically. The deeper you immerse yourself in this research the more you come to appreciate the "fearfully and wonderfully" made mechanism that we are so ineptly attempting to match.

Some hemolysis, cell crenation and fibrinogenolysis will occur with every type of machine. Usually, however, such destructive phenomena fall well below clinically significant levels and the pump, itself, is usually far less responsible than other extracorporeal factors.

Injury to formed elements of the blood appears to be more related to excessive turbulence, jets within the stream, eddies and excess foaming due to improper tube connectors, joints and excessive oxygenation. Every bend, each connection, each gadget in the system serves as a potential injurious factor. Figure 5 illustrates the hemolysing effect of increasing oxygenation rates.

Plasma hemoglobin determinations alone offer a reliable means of estimating cellular injury. A number of other time-taking and expensive studies may be made to assay the destructive forces of a given apparatus. Plasma fibrinogen levels, recalcification time of decalcified plasma, red cell crenation and radioactively tagged red cell studies, are among these. In our laboratory, a standard run on the pump-oxygenator, using relatively high perfusion rates (about 100 cubic centimeters per kilogram per minute) and oxygen flow rate of no more than 3 to 1 per minute, results in plasma hemoglobin levels of 20 to 45 milligrams per cent. These levels are considered well within the margins of safety.



Figure 5. Pump-oxygenator in use at Monmouth Memorial Hospital.
T. Heating and temperature monitoring unit
O. Oxygenator (Type C, Fig. 4)
AP. Arterial pump (artificial left ventricle)
VP. Venous pump (artificial right ventricle)
R. Venous reservoir

METABOLIC ACIDOSIS

IN THE acid-base bailiwick, the glaring dawn of ignorance falls brightest. Early experimental experience brought wonder, time and time again, not at the causes of death, but rather at the reasons for survival! The past two years have yielded much valuable data on acid-base alterations during extracorporeal circulation, but most of these changes must remain unsatisfactorily explained. Directly related to perfusion, time and pressure is the gradual tendency toward metabolic acidosis. This has been shown to be related most often to an increase in unmetabolized pyruvic and lactic acids. This trend ceases after the extracorporeal run and, therefore, is definitely the result of the machine. Administration of bicarbonate during perfusion, using periodic pH determinations as a guide, will considerably offset this acidotic trend.

It may be postulated that alterations in flow volume and/or velocity through certain visceral areas may be responsible for this metabolic acidosis, since it is well known that various metabolic processes are carried out in certain specific anatomical regions. Certainly, disturbances in flow rates through specific regions do occur during mechanical perfusion. Indeed, it has been shown that under conditions of extracorporeal perfusion, the patient behaves as a relatively noncompliant system.[27]

Blood sugar, nonprotein nitrogen, serum calcium and phosphate remain fairly constant as does sodium and potassium. Definite rises in serum chloride occur. Slight drops in serum protein usually result at the expense of the albumen fraction, but sometimes this decrease can be severe enough to reverse the albumen-globulin ratio.[26]

SOME SURGICAL PERPLEXITIES

MOST of the reparable anomalies involve defects in the cardiac septa, the commonest being in the ventricular system. The majority of ventricular septal defects are found high in the membranous portion, that portion of the right ventricular outflow tract lying inferior to the crista supraventricularis. Since these defects usually involve a rather large portion of the muscular septum adjacent to or enclosing important divisions of the conducting system, the suturing of defects here is fraught with the possibility of initiating serious arrhythmias.

One objection to operating within a stilled heart (induced asystole), although technically easier for the surgeon, is the fact that important branches of the conducting network can be caught in the suture line without knowing it until it is virtually too late.[13] When the arrhythmia develops in a beating, open heart, it is a simple matter to remove the stitch. The most effective therapy for surgically-produced arrhythmias (heart block) has proved to be Isuprel® in parenteral form. This is a Winthrop Laboratories preparation.

Large septal defects, which have existed for an appreciable length of time, are often associated with important alterations in hemodynamics involving large segments of the pulmonary vascular bed and great vessels even at a distance seemingly remote. Sudden surgical closure of the prime anomaly, in a single stage, may lead to irreversible cardiac stress incompatible with survival. A number of ingenious methods have been developed which permit rather slow closure of large septal defects. In one instance, a circular plastic prosthesis is sewn within the defect. A hole, containing a mesh screen, in the plastic "button" prevents sudden overloading of one side of the heart by permitting some degree of shunt to remain. Within a few weeks, the screened-in hole gradually closes by the slow process of invasion of fibrocytic elements and eventual endothelialization. Thus, there is a more gradual closure of the septal defect with sufficient time lag to permit cardio-dynamic adjustments.

THE CLOTTING PROBLEM

BLOOD clotting is seldom a major problem.

Once the chest is opened and the great vessels have been isolated for cannulation, and the surgeon has insured himself that all chest wall bleeders are secure, heparin is given in-

travenously. The dose of heparin varies from place to place, but, in the main, lies between 1 and 2.5 milligrams per kilogram.

Considerable quantities of blood may be used for priming the pump immediately prior to operation (2 to 8 pints). To avoid pouring large quantities of citrate into the circulatory system, donor blood is usually taken in a special donor set supplied with a heparin solution rather than the usual A-C-D mixture.* Blood is taken from previously typed and cross-matched donors immediately prior to the operation and is kept warm until used to prime the pump. Fresh, warm blood, with its high platelet count, assures a minimum of difficulties regarding the clotting mechanisms.

Once surgery has been completed and the cannulae have been removed from the great vessels, the clotting mechanism is brought back into force by the use of Protamine.® Doses vary from 1.5 to 3 milligrams of Protamine® per kilogram.

INDICATIONS FOR THE MECHANICAL HEART

AN IMPRESSIVE list of abnormal "living" pathology has fallen to the lot of the cardiovascular surgeon. It continues to grow. Here is a list of lesions now considered applicable to cardiac by-pass technics:

Congenital Anomalies

Ventricular septal defects
Single ventricle
Atrial septal defects
Atrio-ventricular canal
Tricuspid atresia and Ebstein's anomaly
Anomalous pulmonary venous drainage
Pulmonic valvular and infundibular stenosis
Tetralogy of Fallot
Transportation of the great vessels
Aortic sinus aneurysm (congenital)
Anomalous coronary arteries.
Aortico-pulmonary septal defects
Congenital aortic regurgitation
Endocardial fibroelastosis

Acquired Diseases

Aortic stenosis
Mitral stenosis and regurgitation
Ruptured sinus of Valsalva
Intracardiac tumors
Thoracic aortic aneurysms
Ruptured ventricular septum (coronary)

OPEN HEART SURGERY IN THE COMMUNITY HOSPITAL

THE mechanism having become an established fact, ambition for its utilization has become irrepressibly contagious among cardiovascular surgeons throughout the country. An age-old question seems to arise automatically, "Can a thing of this magnitude be done here?"

Some of the commonest reflections of man's seemingly fathomless ingenuity are the excuses he makes. It is amazing to note the variety and the plausibility of his explanations to others (and to himself) for his failures to perform. Too often, the factor of size is referred to as a second-best excuse for failure to achieve, to perform and to equip . . . conveniently forgetting that size is a measure of mass and not energy.

With proper motivation, with a reasonable amount of skill and an insatiable attitude towards work, anything can be accomplished for the patient that lies within human reach in the average community hospital.

Achievement in medicine is not accomplished by virtue of the physical plant called "hospital." It lies within the men themselves who have taken on the responsibilities of medical practice. To be sure, many of the advances in medicine are wrought in the larger city medical centers; but this is not always true. One of the most brilliant researches ever to be carried out in all of medical history took place in the far-off northern wilds of Michilimackinac Island where the waters of Lake Michican and Lake Huron unite. Beaumont, the man and the opportunity had met; it was sufficient.

Sooner or later, what was considered proper for only a large "city center" to undertake, trickles downward (an unfortunate word) to

*The authors are indebted to the Abbott Laboratories for their liberal contribution of ABBO-VAC bottles containing 1500 U.S.P. units of heparin per 500 cc. silicone coated vacuum bottle.

become a part of the everyday routine of the community hospital. Retrospect often reveals inexcusable waste of time, suffering and lives before a new, better and reasonable method or action becomes acceptable. For this phenomenon, there is no physical, practical or literal explanation outside of man himself.

As complex as it may seem (and is), the mechanical heart will, in due time, find its way into the armamentarium of many community hospitals. The public will not be denied for long access to proved scientific resources. Physicians will not be permitted for long to keep "waiting in the wings." It is a definite sign of change to witness the unwillingness of the community hospital to remain on the fringe of medical science, demanding instead to become a functional part of the fabric.

A final word of caution is mandatory. There is one barrier to the attainment of success. No matter how "simple" such devices may become, or the readiness with which patients and colleagues accept the new technology, many hours will have to be spent by the surgical team, subjecting themselves to the disciplines of the experimental laboratory. Only there can familiarization with the intricacies of the mechanisms involved be accomplished.

". . . though a little one, the master word looms large in meaning. It is the 'open Sesame' to every portal, the great equalizer to the world, a true philosopher's stone . . . with this magic word in your heart all things are possible, and without it, all study is vanity and vexation . . . the miracles of life are with it . . . it is directly responsible for all advances . . . it is the measure of success in everyday life . . . and the master word is *work*."[27]

321 Sunset Avenue

A bibliographic listing of 27 citations will be found in the authors' reprints.

State Complains of Poor Blood Specimens

Too many unsatisfactory blood specimens are being received in the State Laboratories in Trenton. Hemolysis is due to freezing. Because of long layovers during weekends there is danger of spoilage of specimens.

Physicians are urged to mail specimens early in the week and to be sure to use dry, sterile equipment in drawing the blood.

New New Jersey ACP Fellows

Four New Jersey doctors have just been installed as Fellows of the American College of Physicians. They are Drs. G. B. Barlow (Englewood); David Biber (Union); William Halbeisen (Camden); and Gerhard Hirschfeld (Glen Rock).

Recently named as Associates of the ACP are Drs. W. B. Abrams of Newark; Arthur Krosnick of Trenton; N. Maurice Re of Palisades; Irving M. Silber of New Brunswick; William A. Tansey of Short Hills and W. J. Woodward of Asbury Park.

George W. Irmisch, M.D.

Trenton

Transurethral Prostatic Resection in the Aged*

Urinary retention due to prostatic hypertrophy is always serious in a man over the age of 80. However, even in that age bracket the patient may be a good surgical risk and death can be postponed by electing to do an operation rather than by temporizing.

The urologic and surgical care of elderly men is a topic which will continue to interest all physicians. Chronologic age is of less importance than physiologic age. Many men are older at fifty-five or sixty than others are at eighty years or older. Degenerative disease often takes its toll before the age of sixty. And while men living to the age of eighty or more are rather vigorous, it must be recognized that such patients present far greater surgical risks than the younger men.

Habein and Thompson[1] have pointed out that the pre-operative examination and care of elderly men are as important as the operative technic. Reviewing 1200 patients, all more than seventy years of age, they also demonstrated, that in addition to the wise choice of anesthesia, certain important aspects of post-operative care must not be forgotten.

I have selected for this presentation a group of men eighty years or older, who have been operated upon by transurethral prostatic resection, utilizing the Thompson resectoscope. These patients were operated upon for benign or malignant enlargement of the prostate gland.

PRE-OPERATIVE EXAMINATION

A complete survey of the patient is indicated, including urinalysis, roentgenograms of the chest and of the area of the kidneys, ureters, and bladder, complete blood count, serologic tests, blood grouping, Rh determination, and electrocardiogram. Blood urea nitrogen, carbon dioxide combining power and blood chloride level are ascertained. These are a basic minimum. Other studies, such as roentgenographic examination of the gastrointestinal tract, gallbladder, proctoscopic examination, special blood examinations (like determination of the alkaline and acid phosphatase levels, sedimentation rate, blood sugar and total proteins) might be done if indicated.

In examining the elderly man, much information can be obtained by physical examination alone. For example, it is well to watch for shortness of breath on exertion, pitting edema of the ankles, the degree of sclerosis and tortuosity of the radial arteries and the re-

*Read May 1, 1957 before the Section on Urology of The Medical Society of New Jersey.

1. Habein, Howard and Thompson, Melvin: Review of Central American Urology, 7:121 (Sept. 1956)

sponse to ordinary questioning. The alert patient replies quickly. He is mentally keen and is usually a better risk than one who is sluggish in physical and emotional reactions. The texture of the skin and the clearness of the eyes, the strength of his grip and response to his surroundings are important things to note. A patient who is obviously interested in the details of his examination and who is reasonably alert is a much better risk than the querulous, arteriosclerotic, sluggish individual. From this kind of examination we determine the patient's physiologic age. Do not depend upon the hospital chart, with its laboratory data, to formulate your decision as to whether the patient is a good candidate for surgery. Consider rather the physical findings at the time of your examination.

In the cases presented below, a considerable amount of degenerative disease is found. Thus we find hypertension, advanced arteriosclerosis, coronary sclerosis with a history of angina pectoris, and significant electrocardiographic changes in more than half of this group. Senility, weakness, diabetes and Parkinson's disease are encountered. Recent cardiovascular accidents often contributed to the surgical risk.

Many elderly men are seen in moderate stages of uremic poisoning. Renal insufficiency, secondary to obstructive urinary disease, with superimposed infection, resulting in fever and chills cause a deterioration which should be avoided at all times. Surgical treatment may be postponed or avoided entirely because the physician caring for the patient is not aware of the comparatively low risk of operation. These people report for examination, either at the office or the hospital, with overflow incontinence, fever and chills, gross hematuria, elevated and disturbed blood chemistries, indicating various degrees of uremia, with resultant mental confusion. They are subjected to temporizing measures such as intermittent catheterization, inadequate chemotherapy and failure to use the proper supportive measures of parenteral fluid supplement or blood. They slip from bad to worse, and finally into a desperate condition. It is relatively simple, as a rule, to keep an inlying catheter of small caliber in place. This will allow the physician to control fever, and assist in the treatment of the patient, who will then be able to receive adequate fluid intake. I further emphasize the use of the inlying catheter since so many of these older men have more than one disease process. I am thinking of the patient with prostatic obstruction and perhaps a malignant lesion of the stomach or the patient with large incapacitating hernias. We frequently see multiple lesions. Here the inlying catheter is very wisely used during the time that other necessary surgical procedures are pursued. The inlying catheter might likewise be used during a period when the operation is delayed while a cardiac condition is being treated. A recent cerebrovascular accident may justify such catheter drainage and delay of surgery for a series of weeks. Anemias may be corrected at this time. While the patient is being adequately prepared, he does not necessarily have to be kept in bed. Getting him up every day is stimulating. It prevents stasis of blood and keeps him interested in the activities around him in the hospital. This stimulates these patients to maintain an interest in surviving.

PRE-OPERATIVE THERAPY

IN PREPARING the patient for surgery immediately prior to the operation, sedatives and hypnotics are to be used very guardedly. Small doses frequently result in maximum effect. On several occasions, we have had to postpone an elective operation, because the patient was prostrated by ordinary routine pre-anesthetic medication.

ANESTHESIA

THE choice of an anesthetic agent is of utmost importance in the patient 80 years of age or older. In this series, inhalation anesthesia was avoided. Intraspinal tetracaine hydrochloride,† in small doses, administered as low in the canal as possible was the anesthetic of choice. Tetracaine dextrose† is a heavy solu-

†We used the Winthrop-Stearns brand of tetracaine, tradenamed Pontocaine®.

tion and 6 to 9 milligrams may be used to advantage. All sensation should be abolished high enough to enable the surgeon to do an operation on the prostate gland. The positioning of the patient has to be carefully planned. The Trendelenburg position is avoided. Anesthesia of the vesical and genital area may be obtained while the patient remains able to move his feet.

Following the positioning of the patient, a needle is placed in a suitable vein for the administration of intravenous solutions. A pint or more of blood is prepared and made available for surgery. Anticipation of a blood loss is important as is the very early initiation of the replacement of the blood. The earlier the blood is started the greater the therapeutic effect.

Oxygen is given to the patient as the situation demands and certainly if intravenous anesthesia is used. The anesthetic agent is not only given as lightly as possible, but the use of an air-way saves considerable embarrassment.

OPERATION

In this day and age of improved anesthetics and antibiotics and a knowledge of fluid balance, the speed in which an operation can be performed is of secondary importance. However, in patients 80 years of age or older, it is not wise to continue a procedure for several hours even though all supportive measures are used. Repeated blood transfusions are not well tolerated in older men and, indeed, are seldom necessary. The determination of the Rh factor has improved this situation. At the present time we see fewer patients die postoperatively with renal insufficiency. This is due to the fact that the Rh factor is determined and the proper blood is administered.

Fortunately, most prostatic urologic procedures can be completed in much less than one hour. Frequently the operation is performed in 20 to 30 minutes. This reduces the incidence of shock and allows the blood pressure to remain stabilized, avoiding cardiac and cerebral anoxia. We cannot forget the arteriosclerosis that exists nor how disastrous a fall in blood pressure can be. During transurethral surgery of the prostate gland, it is wise to perform the procedure as rapidly as possible and to control all bleeding as the procedure is going along. This is readily done with accurate visual electrocoagulation, and loss of blood is kept at a minimum. If surgeons are concerned about blood loss, colorimetric methods have been devised where the actual estimation of the blood loss can be accurately made and properly and adequately replaced.

Transurethral prostatic resection is much safer, as a surgical method of removal of the obstructing prostatic tissue in men of 80 years or beyond. With rapid resection of the obstructing tissue, there is frequently less risk, than to subjecting the patient to weeks, months, or even years of inlying catheter drainage. Once the operation has been done, and voiding is adequate, there is a loss of the patient's disorientation, there are no more fever and chills, the appetite improves, the weakness fades and the patient returns to a more active state. The recuperative powers of these patients are excellent. By using transurethral prostatic resection, hospitalization and bed confinement are reduced to a minimum.

POSTOPERATIVE CARE

It has been my routine practice to place all patients 80 years or older in oxygen the first 24 hours postoperatively either with an intranasal catheter or under an oxygen tent. I find that this prevents cerebral anoxia with its concomitant disorientation. It is also of utmost importance during this time to avoid large doses of sedatives and opiates. These men usually bear pain well. As a matter of fact, some pain is excellent stimulation for them. Anxious relatives or even the nurse on duty will do more harm than good by insisting that the patient be kept very comfortable. A moderately large dose of morphine sulfate, added to a temperature of a degree or two above normal, in the arteriosclerotic patient, will often bring on a severe degree of disorientation. These patients become confused, sometimes climbing or falling out of bed. We frequently find them walking about the corridors with

their catheters dangling. When the patient is placed in his bed, postoperatively and side rails are used, when oxygen is given and sedatives avoided, this situation rarely develops. It is occasionally necessary to engage special nurses for this postoperative period.

The avoidance of large doses of postoperative fluids is likewise important. Frequently an intravenous injection of 1000 cubic centimeters of 5 per cent glucose in water daily is adequate to maintain fluid balance. Antibiotics are used cautiously, and only when indicated. They are seldom justified as a routine procedure.

Early ambulation is of great importance as is the forcing of oral fluids. This prevents fecal impaction. Get the patient out of bed early; encourage him to move his lower extremities freely and frequently and to take deep breaths. All this prevents pulmonary and vascular complications.

Prolonged hospitalization, following surgery, should be avoided. Elderly men do better if allowed to go home early. They should be near their family and back in familiar surroundings. They often have peculiarities of diet, periods of rest and special arrangement of the furniture in their rooms. By allowing them to go home early their will to live is kept active and their physical functions are enhanced. In this series of cases, average postoperative stay was 6 to 8 days.

RESULTS

IN addition to the relief of urinary symptoms, which in most cases is quite complete and dramatic, these elderly men, as a rule, note great improvement in general health and stamina. They sleep better, conserve their strength, have improved appetites and often show marked improvement in mental acuity. Improvement in renal function relieves the uremia and the secondary anemias are soon corrected. They lose the "bad taste", which had bothered them and, as their appetites improve, they eat more, they gain weight, their color is improved and generally speaking, they have a marked return of vigor.

There is also an improvement in the patient's sense of self respect, since they are no longer soiling their clothes with urinary drainage. The diminution in the previous urinary urgency now makes them more eligible members of their households and of society. The operation often earns the gratitude of the entire family. The risk of transurethral prostatic resection is much smaller than the risk of physical disability with its complications of fever and chills, renal insufficiency and other sequelae which result from postponing the operation. Some of these patients who had been on treatment for cardiac insufficiency were found several months following their surgery no longer to require medication. The strain of difficult voiding, with its urgency and nocturia had robbed the patient of his normal amount of sleep. The relief of this allows the patient's organic status to return to normal.

SUMMARY AND CONCLUSIONS

1. Men 80 years of age or older, with disease of the urinary tract, are better risks for surgical procedures than is commonly thought.

2. Severe illness and death can often be avoided or postponed by electing to do an operation rather than carrying on with temporizing measures which in themselves often involve a high risk.

3. Careful pre-operative examination and preparation for surgery are essential. Appropriate nursing care and thorough medical attention can usually improve a patient sufficiently to justify an operation even when he is considered extremely ill. Collaboration of the internist and the urologist is of great importance.

4. The judicious use of sedatives and opiates pre-operatively and postoperatively with the proper selection and administration of the anesthetic agent are essential for the successful result.

5. An operation of short duration must be selected to avoid shock. Alert postoperative management is needed to prevent complications. The use of oxygen is important in every case, with adequate replacement of blood loss and the use of antibiotics when indicated.

740 West State Street

Clarence B. Whims, M.D.

Atlantic City

Diagnostic Aids in Rheumatoid Arthritis*

The serum uric acid, a standard urine analysis, the blood count and the sedimentation rate are Dr. Whims' only routine studies for the diagnosis of rheumatoid arthritis. As the author points out, there is no magic formula yet available that will permit early diagnosis; and, unhappily, no difficulty in making the diagnosis late in the disease.

Unfortunately, a diagnosis of rheumatoid arthritis is not difficult in far too many of our cases: those with typical, severe, long-standing disease and those who have lost the golden opportunity for cure and complete rehabilitation. The history and physical examination will usually suffice in these cases. It is in the non-typical, the early and the mild cases that we experience our major difficulties due primarily to the fact that up to this moment there is no available proof of the diagnosis in rheumatoid arthritis.

Recent study and action by a committee of the American Rheumatism Association offers some help in this direction. I refer to Dr. Marion Ropes' committee which recommended that all rheumatoid arthritis be placed into one of three categories:

(a) the definite.
(b) the probable.
(c) the possible.

Many of the signs and symptoms of rheumatoid arthritis are entirely non-specific and are of no real value in differential diagnosis. I speak particularly of fatigue, fever, anorexia, anemia, leucocytosis, elevated sedimentation rate and the like. As an additional part of their recommendation, we note that for a "definite" diagnosis, joint symptoms of only six weeks' duration are required, and for the category "probable" only four weeks are required. If we are to make a correct differential diagnosis in patients with musculo-skeletal pathology of only four to six weeks' duration, it is mandatory that we use every possible help and aid at our command.

Of paramount importance to all of us is the fact that there is no laboratory procedure which will differentiate rheumatoid arthritis from the other arthritides and that no single test or procedure is always abnormal in (or is constantly abnormal throughout) the course of this disease. More reliable and more constant information can be had by routine use of three simple laboratory studies:

(1) the complete blood count.
(2) the sedimentation rate.
(3) the serum uric acid.

These plus a urinalysis are my only routine studies.

The x-ray department is a good friend, yet

*Read May 1, 1957 at the Annual Meeting of The Medical Society of New Jersey.

†Camp, J. D.: Annals of Rheumatic Diseases, 3:145 (1943)

often a very disappointing one. Usually we receive negative or normal reports in the early cases and often the same even in the moderately advanced stages of this disease. Campbell states: "The pathologic and roentgenographic response of joints in various diseases is too similar to permit dogmatic interpretation of the roentgenogram." A list of the useful diagnostic aids and procedures in rheumatoid arthritis is not too different from the list used in other musculo skeletal diseases. If we include in that list the debatable as well as the useless studies and procedures that have been suggested, the remainder of this week will be spent in this undertaking. Suffice it to say, some are good, others are bad.

5401 Atlantic Avenue

Is Air-Conditioning Harmless?

Effects of air-conditioning on patients with acute and chronic diseases of the nose and throat depend largely upon the relative degree of humidity, according to Dr. Noah D. Fabricant.*

Relative humidity of about 45 per cent is regarded as optimal, although an extreme range of relative humidity from 30 to 65 per cent is assumed to be tolerable.

"The relative humidity of outdoor summer atmospheric conditions is high in many communities. When air is taken indoors and chilled, the relative humidity becomes even higher. Under these circumstances, perspiration from the skin does not evaporate readily, and patients soon become aware of chilling. Attacks of rhinitis, sinusitis and tonsillitis are some of the sequelae." Dr. Fabricant suggests that summer air-conditioning calls for dehumidification, while in winter a higher humidity than exists in the outside atmosphere should be provided.

"Low relative humidity sometimes predisposes to respiratory tract diseases. However, patient response varies. Low humidities—15 per cent or less—are usually detrimental and result in drying of the nasal mucous membranes, so that the nasal mechanism is sometimes unable to cope with upper respiratory disease onslaughts." There is a definite need for additional nose and throat observations on the effects of air-conditioning on these structures."

*Fabricant, N. D.: Ear, Eye, Nose and Throat Monthly 35:584 (Sept.) 1956.

A Good-Will Booklet for Your Patients

What Everyone Should Know About Doctors is a new 16-page booklet that uses a novel picture-and-word scriptographic technic to present basic facts about our profession. It is designed for lay distribution through tables or reading racks in your wating room.

This is a new approach to the problem of highlighting the importance of regular physical examinations. Many laymen are unaware of the need, and others are afraid of what they'll find. On both counts, more knowledge is needed.

What Everyone Should Know About Doctors takes the first step in providing that knowledge by using its fast-communication scriptographic technic to drive home some basic points. Combining descriptive line drawings with simple language that make it inviting to read and easy to understand, this booklet points out that the medical profession has already increased the average life span by 20 years, lists the steps to a medical education, tells what's in the average doctor's bag, urges regular physicals, describes the surgical and medical specialties, and otherwise contributes to better public understanding of the doctor's role, what's behind it, and how much it contributes to the common weal. All in 16 pages.

The booklets are sold to physicians at a nominal price. For details, write to the Channing L. Bete Company of Greenfield, Massachusetts.

The Role of Insurance in Meeting the Costs of Medical Care

I. HEALTH INSURANCE FUNDAMENTALS

For better or for worse, private practitioners are now part of the insurance pattern of the country. It is not enough for the doctor to know the science and art of medicine. He must also understand something of the fundamental principles of health insurance.

MEETING the costs of hospital and medical care, in addition to family living expenses, is a serious problem for many patients. Voluntary health insurance is contributing a partial, but increasingly significant, answer to this question even for those subject to the largest health expenses.

Physicians have long recognized the importance of health insurance to their patients. Through their own Blue Shield, they have provided certain types of insurance. They have also been aware of the growing body of insurance provided by the nation's insurance companies and have gladly cooperated in making this insurance as effective as possible for their patients.

Within the past year, a liaison committee of The Medical Society of New Jersey* has been appointed to confer with representatives of the Health Insurance Council, an organization of insurance trade associations whose member companies provide 90 per cent of the health insurance underwritten by insurance companies. The Joint Committees will concern themselves with matters of common interest relating to health insurance. One of their concerns is the dissemination of information regarding the role of insurance in meeting the financial needs associated with accident and illness. Accordingly, a series of three articles on health insurance, of which this is the first, has been prepared under the sponsorship of the Joint Committees, for publication in THE JOURNAL. This article discusses some of the fundamentals of health insurance; the second will focus on the contribution of the older or customary types of voluntary health insurance; and the third will center on the broad new type of protection, major medical expense insurance.

NATURE OF INSURANCE

THE insurance concept may be described briefly as follows:

1. Relatively small, regular premiums are paid into an insurance fund by or for a large number of persons subject to a given hazard or group of hazards.

2. The money thus assembled is used to provide economic recompense for the relatively few persons who actually are stricken by a hazard insured against.

*Dr. Daniel F. Featherston is Chairman of the Medical Society's Committee. Other members are Dr. F. Clyde Bowers, Dr. Marcus H. Greifinger, Dr. J. Wallace Hurff, Dr. Jesse McCall, Dr. Royal A. Schaaf, Dr. Rudolph Schretzmann, and Mr. Richard I. Nevin, Executive Officer of the Society. Dr. B. T. D. Schwarz, Vice-President and Medical Director, Bankers National Life Insurance Company, and Dr. Irving Ganot, Medical Director, The Prudential Insurance Company of America, are among the members of the Health Insurance Council's Committee, which is under the chairmanship of Mr. Ardell T. Everett, Second Vice-President, The Prudential Insurance Company of America.

The essential function of an insurance company is to serve as a mechanism to put this plan into effect. The company enters a separate contract with each policyholder—the policyholders are not contracting with one another. Obviously, the aggregate premiums collected by the company must be enough to support the aggregate benefits offered. At the same time, competition among insurers tends to keep premiums at the minimum necessary to support the benefits. So, in long-run terms, reduced benefit payments mean lower premiums while higher payments mean higher premiums.

No new money is created by insurance. In fact, the money available for medical expenses is reduced by the necessary administrative expenses of the insurance operation. Yet it is worthwhile for the insured population to bear this administrative expense in order to spread the risk of much greater medical expenses.

SMALL RISKS—AND BIG ONES

THE risk-sharing function of insurance is of greatest value when the risk insured against is a serious one and when its occurrence is infrequent. It is not worthwhile for the insured population to bear the administrative expense of paying minor sums to a large proportion of those who are insured; the money is better spent in paying substantial benefits to the small proportion who incur severe losses.

From the family's standpoint, the costs of relatively frequent, minor sicknesses and injuries can best be allowed for in the family budget. If such allowance is made, no real financial difficulties are likely to develop, at least none that could be appreciably eased by the use of insurance methods. In fact, there is but little more reason to seek to insure against small, recurring health outlays than to seek to insure against any other regular expense.

One of the chief methods of separating budgetable items from more serious financial blows is through the use of "deductibles" (a familiar feature in automobile liability insurance). In health insurance, a deductible can take various forms, such as a specified amount of money, a specified number of doctor's visits, or a specified number of days of sickness.

For example, a waiting period of a week or a month may be required before reimbursement for lost income begins. Or, reimbursement for medical expenses may exclude any payments for bills aggregating less than $50 or $100, and may reduce larger claims by such an amount. Most families can meet such expenses out of regular income or savings, and in such cases the deductible should not place too great a strain on the family's finances. Moreover, deductibles generally enable the same premium to purchase much larger benefits, payable in case of the more serious illnesses.

VOLUNTARY HEALTH INSURANCE

BOTH quantitatively and qualitatively, voluntary health insurance has shown spectacular progress in the past twenty years. From just a few million persons covered two decades ago, coverage had increased to 123 million with some type of voluntary health insurance by the start of 1958. At the same time, the amounts and types of benefits available have steadily increased. In contrast with the less liberal policies of earlier times, insuring organizations nowadays offer many attractive policies providing broad protection against serious illnesses.

Despite this recent progress, there are still millions of persons who need health insurance but who have not yet acquired it. Similarly, many people possess protection only against the first dollars of expense, with no provision for the less frequent but far more serious occasions which, without insurance, can cause financial disaster. Thus, health insurance has not yet achieved its full potentiality in meeting the financial needs of the patient with the greatest expenses. But much has already been accomplished, and the future outlook is bright.

Voluntary health insurance contracts can be classified: (a) by the health hazard insured against, (b) by the form in which benefits are paid, (c) as group and individual policies, and

(d) by the cancellation and renewal provisions.

Hazards insured against. On this plane, health insurance is usually divided into five types: protection against loss of income, hospital expense protection, surgical expense protection, regular medical expense protection and major medical expense protection.

Information on each of these types of protection will be given in the other two articles of this series. A single health insurance policy may provide two or more of these five types of protection.

Forms of payment. The form in which benefits are paid is determined by the relationship among the three interested parties: the insuring organization, the policyholder or insured person, and the individual or organization (usually doctor or hospital) that actually furnishes the services. Ordinarily, an insurance company contract is entirely between the company and the policyholder or insured person. There is a flow of cash from those insured to the company in the form of premium payments, and a reverse flow of cash in the form of benefits. The insured individual may select the person or organization from whom he wishes to receive services and may make his own arrangements as to price he will pay, the company taking no part in these relationships.

This simple type of two-party relationship is not confined to insurance companies, but also exists, to a limited extent, in Blue Cross and Blue Shield plans. Thus, if a subscriber goes to a hospital not affiliated with Blue Cross or a doctor not participating in Blue Shield, cash benefits are usually paid. However, for the most part, Blue Cross and Blue Shield contracts involve the three interested parties in somewhat closer relationships than do the cash-benefit arrangements of the insurance companies.

Like insurance companies, Blue Cross and Blue Shield issue contracts involving premiums and benefits between those insured and the insuring organization. In addition, they enter into contracts with the doctors and hospitals who are to supply the services, specifying the services to be provided, the payments to be made in return, and for what services, or under what circumstances, additional charges may be made to the patient.

Most of the independent plans, sometimes called "consumer-sponsored" plans, involve an even closer relationship among the three parties. Those who are to render the services are usually placed directly on the payroll of the organization offering the insurance, either on a straight salary, a fixed amount per patient, or other basis. Likewise, the insuring organization may be the direct owner of the hospital or other facilities to be utilized in rendering the services.

Group and individual insurance. The insurance contract may be made directly between the individual and the insuring organization, or a master contract may be made between an insurer and the representative of a group of persons to be insured. In either case, protection is generally available for the dependents of the primarily insured persons.

In group insurance, the "master policy" is usually between the insurance company and an employer, giving protection to the employer's employees, and often to their dependents. In recent years, group insurance methods have been applied to groups other than the employees of one employer. Employees of numerous employers joined together in a trade association, members of trade unions, members of various farmers' organizations, and members of professional societies are among those who have been able to obtain group insurance through some group other than the employees of one employer. The group method is used not only by insurance companies but also by Blue Cross, Blue Shield, and most other health insuring organizations.

However, some people are not connected with an insurable group and hence are beyond the reach of the group method. Also, the group insurance of many families does not cover both income loss and the various types of hospital and medical expense. Thus, there will be a continuing need for individual and family policies, both to provide protection for those not having group insurance and to provide supplementary benefits for those whose needs are not fully met through the group approach.

Cancellation and renewal provisions. The most common type of policy is renewable from year to year at the option of the insurer. Some of these policies may be cancelled by the company during the term of the contract, with *pro rata* refund of premium, and from this circumstance the whole class of policies takes the name of "cancellable." The right of cancelling (or failing to renew) such a policy is seldom exercised, often only if the policyholder appears prone to claim benefits when their payment is not morally justified. Increasingly, insurance companies are stipulating that they will not refuse renewal solely because of deterioration in health.

Within the past six years, companies have begun issuing policies in which the right of renewal is guaranteed to the policyholder, while the company reserves the right to adjust premiums by class of risk (not by individual policyholder) if experience indicates that such a step is advisable. This type of renewal provision is gaining considerable acceptance, particularly in the expense-of-treatment policies.

IS HEALTH SUBJECTIVE?

MOST of the difficulties in developing successful health insurance plans stem from the subjective side of illness. These difficulties create the problem of control. Human health has a subjective component and medicine is not an exact science. Agreement cannot always be expected on answers to such questions as: Does the patient need to go to a hospital? Is a private nurse needed? May the patient now return to work?

But if medical opinion has been known to vary, the patient's appraisal of his own condition is subject to much wider variation. Among several persons having the same condition, so far as can be determined by objective tests, one may shrug it off and go to work as usual. Another may take to his bed. Still another may make an emergency call to his family physician, while a fourth may demand to go to a hospital.

Insurance benefits involve additional subjective factors. Some who would go to work if staying home meant losing income will remain at home if benefits are payable. Likewise, some one who would not call the doctor if they expected to pay him themselves will do so if benefits are available.

The tendency of health insurance to increase the public's demand for health care is not undesirable. With earlier and more adequate attention, the illness may be less serious, and complications may be avoided. But there is a point where the socially desirable increase in medical attention ceases and the availability of insurance can lead to needless absences and unneeded hospital and medical care. Even in such cases, outright fraud is seldom involved. Usually it is just that the individual is encouraged, more or less unconsciously, by the insurance to carry to an extreme, his normal concern about health.

THE PROBLEM OF CONTROL

COMPANIES must find a way of dealing fairly and reasonably with these subjective considerations if health insurance is to serve its purpose.

Insurance companies exist in order to pay benefits. On the other hand, in fairness to the great majority of policyholders, they must not pay unnecessary benefits. To do so would mean that premium charges would have to go up without any increase in the true value of the benefits offered. This problem of control—how to provide benefits when needed without providing benefits when not needed—is faced by insurance companies, Blue Cross, Blue Shield, and all other health-insuring organizations.

Development of a careful statement of the risks which the policy insures against, and of the benefits payable under it, is the first step toward solving the control problem. Carefully outlining the scope and benefits of the policy, of course, does not make certain all benefits paid will be of real value, but it does serve to

define the area within which the problem exists.

A word may be in order here about the "fine print." While many users of this expression are merely referring to policy restrictions and limitations generally, there may be others who have the notion that such provisions are literally written in small type. Actually, health insurance policies are printed in large type, and *it is illegal for any policy to give more prominence to its positive benefit provisions than to its restrictions and limitations.*

Policies and service-plan contracts do contain some restricting or limiting provisions to the extent necessary to spell out the risk insured against. Group insurance, which even provides benefits with respect to pre-existing illnesses, ordinarily contains no limiting provisions other than those necessary to define the risk. For individual and family policies, however, the safeguards inherent in group underwriting are lacking. Consequently, a few limitations are essential in such policies, while a few others are considered desirable by many companies.

Overinsurance and coinsurance. Overinsurance is present if the policy benefits are more than sufficient to cover the losses suffered or the expenses incurred. For example, if a man's "take home" pay is $100 a week, overinsurance would clearly be present if his loss-of-income policy provides benefits of larger amount. On the other hand, suppose that his policy provides $90 a week; suppose also that, as he recovers from an illness, he feels he would rather continue to rest at home drawing benefits, then return to work for the sake of the small difference in income. In such a case, the temptation to protract the convalescence period unduly is essentially the same as if the weekly benefit had been over $100. Something closely akin to overinsurance is present—something that goes to the heart of the basic control problem. Insurance companies rely largely on the coinsurance principle in dealing with this "something."

Coinsurance is a sharing of the risk by the insured person and the insuring organization. A specific coinsurance percentage may be stated in the policy, as in major medical expense insurance; or the same effect may be achieved by providing benefits which will cover somewhat less than the full cost of hospital or medical services or the full amount of lost income. As a coinsurer, the policyholder is expected to carry a portion of the risk himself.

The insurance company tries to set the benefits available under any type of policy at as high a level as possible, while still leaving an adequate incentive to the insured person to avoid unnecessary work absences and needless health expenditures. As long as the insured person knows that to incur needless bills is against his direct self-interest as a coinsurer, he has that incentive. Through coinsurance, companies have been largely successful in providing benefits when they are desirable while preventing the payment of needless benefits.

The primary purpose of coinsurance is to enlist the financial self-interest of the participants in the insurance in preventing the payment of needless benefits. But the furnishing of needless benefits is equally harmful to the interests of the participants, whether the benefits are in the form of cash or not. So, service-benefit plans must utilize some equivalent of coinsurance in order to cope with the control problem.

In Blue Cross-Blue Shield, the participating hospitals and physicians often agree that they will accept *pro rata* reductions in their remuneration if the aggregate subscription fees received proved inadequate to compensate them at the stipulated rates. By such agreements, the hospitals and physicians become the ultimate underwriters or reinsurers of the plans in which they participate and hence have a direct incentive to prevent over-utilization of their services.

In practice, this is not always adequate to check excessive demands for hospital and medical care. If x-ray and other ancillary services, for example, are available to the patient at no added cost, there is little incentive for him to exercise restraint. The eventual effect of

any lack of success in solving the control problem is, of course, to increase subscription charges for participants generally.

FIXING PREMIUMS

PREMIUMS comprise two elements: (a) *the pure premium*, an amount calculated on an average to cover exactly the cost of the benefits offered; and (b) *an expense and safety allowance*, which is intended to cover an equitable share of the necessary operating costs of the insurance, together with a small margin for safety and profit.

Pure premiums are directly proportionate to the likelihood of the hazard's occurring and to the benefits payable if it occurs. Because this proportionate relationship is not greatly affected by the expense and safety element, it does not ordinarily pay to look for bargains in health insurance. The best bargain is a policy that fits the family's needs particularly well, while the poor buy is a policy that does not meet its needs.

CONCLUSION

THIS initial article in a series of three has presented some basic information about the nature of health insurance. The emphasis has been mainly on fundamental principles rather than on technical aspects. The two articles to follow will provide more specific information on the various types of health insurance, which have been mentioned here only briefly, and on the role of each in meeting the costs of medical care.

As in this article, attention in the succeeding articles will be given mainly to the insurance companies' approach to health insurance. However, it may be emphasized here that all approaches have their advantages, both in themselves and as competitive spurs to further development. Certainly the growth of health insurance and its increased public acceptance have stemmed largely from competitive factors, and the force of competition has been largely responsible for the increasing extent to which health insurance offers financial protection against the expenses of accident and illness.

Results of Routine Sigmoidoscopy*

Of 150 patients over 40 years of age who had a routine anorectal and sigmoidoscopic examination, 1.25 per cent were found to have carcinoma; 6 per cent, polyps of the rectum; 20 per cent, hemorrhoids, 5 per cent, pruritis ani; 2 per cent, fissures in ano; and 3.5 per cent, enlarged papillae and fibrous polyps. Thirty-three per cent showed no anorectal disease.

In 10,000 consecutive admissions of general-practice patients 3.5 per cent showed anorectal or colonic diseases. Of these 30 per cent had hemorrhoids; 15 per cent had pruritis ani; 10 per cent had fissures in ano; 7 per cent had enlarged papillae or fibrous polyps; 5.3 per cent had low proctitis; 3.5 per cent had redundant prolapsing rectal mucosa; and 3 per cent had fistula in ano and abscess.

Digital and proctosigmoidoscopic examinations, routinely done on all patients, are simple and effective methods of detection of rectal cancer.

*Speare, G. S.: New England Journal of Medicine, 255:377 (August 23, 1956)

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Treatment of Psychiatric Disorders in Mental Defectives with Perphenazine

The mental defective with a psychiatric disorder carries a double burden of disability. Some assistance has been afforded in the handling of the psychiatric side of this problem by the administration of perphenazine.

It is the purpose of this paper to report our observations on perphenazine,* a new tranquilizing drug, in mentally deficient patients. We wanted to see whether perphenazine* was an effective drug in the treatment of retarded patients, and if so, to study its dynamic effects.

Perphenazine* is an amino derivative of chlorphenothiazine, with the generic name of perphenazine and the following formula: ((1-(2-hydroxyethyl) - 4 - 3 - (2-chloro-10-phenothiazinyl) - propyl piperazine)). It has been extensively studied pharmacologically.[1,2,3]

The use of this drug has been suggested in "mental and emotional disturbances manifested by anxiety, tension, agitation, panic, confusion, agitated depression, restlessness, psychomotor excitement, and in post-alcoholic states."[4] About 10 per cent of those committed to a residential training school show overt psychiatric problems. Intensive psychotherapy is difficult with a person whose insight and judgment are seriously impaired by the primary mental deficiency and distorted by the psychiatric over-lay. Tranquilizing drugs have helped minimize the overt manifestations and have been effective in controlling the behavior. Following chemotherapy, the patients are usually better adjusted to their environment and are no longer managerial problems.

In a preliminary report Ayd[5] observed improvement in 19 of 25 senile arterio-sclerotic patients. His criteria were: (1) *marked* improvement meant complete remission from overt symptoms of a psychosis or neurosis, and (2) moderate improvement signified a sufficient degree of symptomatic relief to permit the patient to function satisfactorily. In a later study Ayd[6] showed improvement in 216 of 300 patients. He concludes that "Trilafon®

*Tradenamed as Trilafon®. A generous supply of Trilafon as Sch 3940 was made available by J. Black, M.D., Clinical Research Division, Schering Corporation, Bloomfield, New Jersey.

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4. Confidential data, released by the Schering Corporation, Bloomfield, N. J.
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is not specific for any psychiatric illness but is most likely to be beneficial whenever anxiety, agitation or psychomotor excitement occur regardless of the duration of these symptoms."

METHOD

TWENTY-FIVE consecutive patients from a resident population of mentally deficient females, referred because of various psychiatric disorders, were selected for the study. These patients had an age range from 9 to 73 years (average 42) and an I. Q. range from 10 to 62 (average 36). Each patient was interviewed by both a physician and a psychologist. The patients were classified as follows:

Behavior disorders	18
Senile psychoses	3
Schizophrenic reactions	3
Neurosis	1

A diagnosis of behavior disorder was given to those patients showing one or more of the following characteristics: psychomotor excitement with or without anxiety, constant quarrels with fellow patients or attendant staff, noisiness, abuse of other patients, and other antisocial behavior.

It was decided to study the areas in which a change would occur rather than merely observing the degree of improvement. To accomplish this, projective technics were selected that would show longitudinal changes in the test profile by both subjective and objective means. The Machover Figure Drawings and the Tree Test were used to set the subjective criteria and the Szondi Test to supply the more objective findings. The one series of tests were to be used to support the other.

The Machover Figure Drawing Test[7] evaluates personality through drawings of the human figure. It is not restricted by the patient's age, intelligence or cultural background. It is actually, the drawing of the body image which readily shows the patient's complex reflection of self-regard, particularly in its pathologic needs. In that there is no stereotyped performance required, this test lends itself to longitudinal studies. The Machover Test[7] has been used successfully to gauge the degree and areas of improvement resulting from a course of psychotherapy. The scoring criteria of Machover were adopted.

The Tree Test as developed by Koch[8] is easy to administer and is not bound by intelligence and age. The Tree as the Figure Drawings, are self-images and project wishes and needs. The Tree is less personal and often supplies additional information which is, by its nature, too dangerous to the person's ego to be associated with something so obvious as a human figure. It too, has a breadth of expression and can be administered repeatedly without the 'training' distortion.

The Szondi Test[9] is more formalized and lends itself to objectivity. The patient is presented with six equated groups of photographs, each group containing eight pictures. A judgment is required as the patient is asked to state which two of each group he likes best and which two least. The results of the six groups, giving a total of 12 'likes' and 12 'dislikes' are tabulated and placed on a graph. By serial testing', we may then know the quantitative change of judgment. Again, the self-image is portrayed and one can read the shift.

After the initial psychological evaluation, and after receipt of a written evaluation from the patient's building supervisor, the patients were placed on perphenazine.* No therapy other than this drug was used. This would eliminate variables that could interfere with our understanding of the drug's primary action. For this reason, no supportive psychotherapy was used. The initial dosage was 4 milligrams twice a day, which was increased at weekly intervals if evaluation showed no appreciable improvement. Response to the drug was variable. The top dosage used was 12 milligrams three times a day. Following six weeks of chemotherapy, the patients repeated the battery of tests previously administered. Results were again interpreted and evaluated to indicate the shift, if any, from the initial to the second testing.

RESULTS

ALL patients were evaluated clinically after 6 to 10 weeks of chemotherapy. The entire group included in this study was administered

7. Machover, Karen: Personality Projection in the Drawing of the Human Figure. Charles C. Thomas, Springfield, Ill. (1953).

8. Koch, Charles: The Tree Test. Hans Huber, Publisher, Berne, 1952.

9. Deri, Susan: Introduction to the Szondi Test. Grune and Stratton, New York, 1949.

the projective tests, but it was immediately apparent that 16 could not comply with the instructions either because of the severity of the mental retardation or because of psychiatric preoccupation. Invalid psychologic reports are not included in this report. The remaining 9 patients submitted tests that were properly completed and the observers felt that the correct subjective materials were portrayed. A summary of their combined test results follows:

PSYCHOLOGIC EVALUATION

In most cases, the dependency needs became more pronounced, but this was accompanied by a certain amount of frustration in the form of hopelessness. Projection increased in some of the patients and this seemed to satisfy the need for an anxiety outlet. In nearly all, the amount of aggression increased markedly. In most it was characterized by aggressive hostility, but in others through some form of outlet, presumably tension. In each record, we saw a greater degree of emotional control, but this was not accompanied by insight or awareness. Apparently, the patients attempted to control their behavior and conform. Depression, even when it was not present during the first testing, increased or remained static in every case. In some cases there was an increase of normal depression without any characteristics of pathology. Tension was seen to increase in some and decrease in others. This did not seem to be correlated with any other point. There was an increased ambivalence with regard to others and this caused a worsening of interpersonal relations. Restless feelings were more pronounced.

The factors dependency, aggression, emotional control, tension, ability to form satisfactory interpersonal relationships and depression were selected as those areas which seem to be most affected by the therapy. The results are given in the table.

Case	Dependency	Aggression	Emotional Control	Tension	Ability to form Relationships	Depression
1	+	+	+	—	0	+
2	+	+	+	+	0	0
3	—	+	+	+	—	+
4	+	+	+	+	+	0
5	—	+	+	+	—	+
6	+	+	+	0	—	0
7	+	+	+	+	—	+
8	+	+	+	—	0	+
9	—	—	+	—	—	+
Increases	6	8	9	5	1	6
Decreases	3	1	0	3	5	0
No change	0	0	0	1	3	3

+ = increase O = no change — = decrease

CLINICAL EVALUATION

ALL 23 patients were evaluated clinically after 6 to 10 weeks of chemotherapy. This was done by two of the authors who were in receipt of the nursing and *managerial* reports prepared by the individual building supervisors. This indicated that 21 had improved and 2 had not improved.

Degree of improvement could not be correlated with the dosage. Some patients required only 8 milligrams daily as compared to 36 milligrams with equal improvement.

SIDE EFFECTS

ALTHOUGH no *serious* side reactions were seen, the following of minor importance were observed:

5 had tremors
3 had parkinsonism-like syndrome
2 had insomnia
2 had anorexia

The pulse rate and blood pressure were not changed appreciably in any instance. Although most patients tolerated 24 milligrams daily without side effects, one developed a parkinsonism-like syndrome on 8 milligrams a day after 30 days of therapy.

COMMENT

IN 23 out of 25 patients, the psychiatric disturbance had subsided and the patient was no longer a *managerial* problem. To evaluate the psychologic summary in the table, the subjective evaluation of the building supervisors and the clinical observations of the authors

must be taken into account. *The psychologic picture would suggest managerial problems, but since these were absent, it would follow that the increase in aggression, tension, dependency and depression was kept under control by an increase in the emotional control factor.* Inability to form interpersonal relationships is not directed by emotional control and therefore, may give rise to tension. This is not inability for contact, *per se*, that has been affected, but is an increased desire to form such contact (increased dependency) and being unable to do so because of lack of knowledge and experience. Help in accomplishing this, under other circumstances, would have come from supportive therapy. Although there has been a release of aggression, this has not been observed in an overt form. There is much evidence that a socially accepted outlet has been utilized.

This whole picture speaks of the action of the drug: an action which has caused a weakening of the defense reactions. This statement would explain the increased tendency to dream, as noted by Ayd[5] — a subsequent healthy "acting out" of the pent-up aggression. The drug's action has been to weaken the defense mechanisms which have caused a restrictive and antisocial personality. It has increased emotional control so that the patient can now conform, and it has made them dependent and amenable to supportive type psychotherapy.

SUMMARY AND CONCLUSIONS

1. Perphenazine* is an effective agent in treating psychiatric disorders in the mentally defective.

2. No serious side reactions with our small group were encountered.

3. Dosage has to be individualized for each patient.

4. Drug administration should be accompanied by supportive therapy, to assist the individual in answering his dependency needs.

5. The Machover Figure Drawings, the Tree Test and the Szondi Test have been given to 9 defective but testable subjects. These tests indicate that, following drug therapy, these areas show a significant increase: dependency, aggression, emotional control, and depression.

6. The ability to form interpersonal relationships is decreased.

7. Symptomatic improvement is noted.

The State School

Dry Ice Poisoning

Asphyxia from dry ice is a potential hazard to motorists who use dry ice as a cooling agent in automobiles during hot weather, according to A. L. Walter.*

Since such motorists drive with windows closed, a potential hazard exists of which they are entirely unaware. Automobile accidents in the past may have been due to the side effects of carbon dioxide intoxication.

Carbon dioxide in 10 per cent concentration may produce unconsciousness. Larger quantities may cause death by suffocation.

Walter* cited a couple who were overcome by carbon dioxide intoxication while driving in a car with windows closed. In the back of their car they were transporting 60 gallons of ice cream sealed in cartons packed with 100 pounds of dry ice.

"Dealers in dry ice should be alerted to this danger and should warn customers to have adequate ventilation in cars carrying dry ice," Walter* concluded.

*Walter, A. L.: Carbon dioxide intoxication. Missouri Medicine, 54:436 (May) 1957.

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Malformation of the Anus and Rectum

A busy obstetrical service will see an occasional anorectal malformation. In this paper, Gross' simplified scheme for classification is presented and two illustrative cases are cited.

Malformations of the anus and rectum occur about once in every five thousand newborns. Many of these represent arrest or abnormalities of development in the fifth to the ninth week of embryonic life. Gross [1] has classified these cases into four types with the idea of correlating the treatment with each.

Type 1: Stenosis of the anus or rectum.

Type 2: Imperforate anus, the obstruction being membranous.

Type 3: Imperforate anus, the rectal pouch ending blindly some distance above anus.

Type 4: Anus and lower rectal pouch normal, but upper point of rectum ends blindly a variable distance from the lower pouch.

Seventy-five to ninety-three per cent of the abnormalities are of the Type 3 variety.[1,2,4] Forty to eighty per cent of this type have associated fistulas.[1,2,4]

This paper discusses the management of two cases of Type 3 form of malformation of the anus and rectum with associated fistulas.

CASE ONE

A three-year old girl was hospitalized because of recurrent fecal impactions. Following a full term normal spontaneous delivery, an anal atresia with a rectovaginal fistula and a congenital hypoplasia of the right eye was noted. Subsequent growth was normal. Physical examination on admission disclosed the vagina to be divided throughout its total length by an anterior-posterior septum. The anus was imperforate but strong sphincter tone was present. A fistulous opening between the posterior fourchette and hymen admitted an index finger into the rectum. The rectum extended to within one centimeter of the anal skin.

Treatment consisted of dividing the fourchette and anterior half of the external anal sphincter. The fistulous tract was dissected free from the vagina and rectum. The rectal wall was freed up and brought through a newly created opening between the anal sphincter. The vaginal septum was divided up to the cervix. After approximating the levatores ani, the vaginal wall was closed. The anal sphincter and perineal body were reconstructed and the rectal mucosa everted and approximated to the skin.

CASE TWO

A four-pound, nine-ounce, seventeen and one-half inch boy was born to a thirty-five year old primipara. At birth, no anal opening was discovered. Within sixteen hours, roentgenograms of the abdomen using the Wangensteen-Rice [6] method indicated that the air had reached the distal ileum. Repeat roentgenograms forty hours after birth revealed the distal air column to be in the rectum four centimeters from a skin marker over the anus. A small collection of air was noted in the bladder. Previous urinalysis showed no meconium.

Within this forty hour period, the abdomen became moderately distended. Moderate dyspnea and tachypnea developed. Two days after birth, under local one-half per cent procaine anesthesia, a loop sigmoid colostomy was performed. The postoperative course was smooth except that the urinary output diminished. On attempting oral feeding by dropper, the infant became severely dyspneic and cyanotic. After resuscitation, his condition remained tenuous, which precluded further investigation for a tracheoesophageal fistula. Two days after the operation, he died.

Autopsy revealed the patient to be replete with congenital anomalies such as a large patent ductus arteriosus, esophageal atresia with the lower segment communicating backward with the trachea, a rectourethral fistula and atresia of the lower rectum with associated imperforate anus, stenosis of the ureter with hydronephrosis, and agenesis of the gall bladder.

In each case, there was anal atresia with rectovaginal and rectourethral fistulas respectively. In Case 1, the fistulous tract was sufficiently large to allow fecal passage. Thus, definitive surgery was delayed three years. In Case 2, there was intestinal obstruction which demanded immediate decompression.

The repair of the rectovaginal fistula in Case 1 was patterned after the work of Santulli.[4] Three years after the operative procedure, the patient was experiencing normally controlled bowel movements per anus.

The management of Case 2 depended upon the position of the rectal pouch in relation to the anus. The anal membrane was sufficiently thick so that no rectal bulge could be palpated. Ordinarily, swallowed air reaches the rectum within twenty-four hours. It required an extra twenty-four hours in this case for enough aspirated air to pass through the tracheo-esophageal fistula into the intestinal tract and reach the distal rectal pouch. When it was determined that the rectum was four centimeters from the anal skin, two alternative courses were open: a temporary sigmoidostomy, or a definitive abdominoperineal procedure. The sigmoidostomy was elected because the child was premature and a poor surgical risk.

The coexistence of other congenital anomalies with anorectal malformations ranges from thirty-nine to seventy-two per cent.[1,2,3] Nearly half of the deaths in anorectal cases are due to related anomalies.[3] Turell[5] reports the urinary tract to be affected in about one of three cases, not including rectourinary fistulas. Megaloureter and hydronephrosis are common. It was renal impairment and the esophageal atresia which were responsible for patient's death postoperatively. Although a meticulous attempt at water and electrolyte balance was made, urinary retention caused peripheral and central edema. The esophageal atresia led to an aspiration pneumonitis.

CONCLUSION

THE management of two cases of the Type 3 (Gross[1]) form of atresia of the anus and rectum is presented. One patient was treated successfully. The other died as a result of concomitant congenital anomalies.

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Spontaneous Healing of Choledocho-Duodenal Fistulas

Not all internal biliary fistulae have to be tampered with. As Dr. Giuffra shows in this brief communication, spontaneous healing can occur.

An internal biliary fistula is always a therapeutic challenge, especially since there have been numerous reports of spontaneous healing. Certainly internal biliary fistula is not, *per se*, incompatible with an uncomplicated clinical course. Actually, a non-pathologic relaxed sphincter of Oddi may occasionally allow reflux of the biliary contents. To help differentiate this condition from others, it is interesting to recall that in the presence of a fistula, barium is retained in the biliary system for 6 or more hours, while there is rapid elimination in the presence of a relaxed sphincter.

Many excellent papers and books discuss etiologic factors in the formation of these fistulas. In general, gall stones are the provocative agent in 90 per cent and perforating peptic ulcers in 6 per cent of the cases.

The most significant factor in the maintenance of a fistula between the common duct and the small intestine is a persisting common duct obstruction. When this obstruction is relieved there is a tendency for the fistula to disappear.[1] Internal biliary fistulas may remain uncomplicated for many years. One patient was reported as having lived 19 years with this condition.[2] However, if obstruction of the common bile duct is present, liver damage and infection may occur.

Cases have been reported in which all biliary symptoms subsided after the gall stones had eroded into the duodenum and were evacuated with the feces. Many fistulas resulting from a duodenal ulcer, have been reported as healing after strict medical ulcer therapy.

A spontaneous internal biliary fistula may be an attempt at self-healing, the fistula being a complication of a pre-existent pathologic process.[3] At times, the initial pathologic process may disappear following the formation of the fistula. The fistula may then heal.

There are many types of internal biliary fistulas, such as communications between the gall bladder and esophagus, stomach, small intestine, colon, urinary tract, and so forth. The other types of communications include a fistula between the common duct and the duodenum; choledocho-duodenal fistulas. It is to this latter type that my thoughts have been directed.

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Historical Article • • •

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The Heritage of the Autopsy

The autopsy is the foundation stone of pathology. An autopsy rate is one of the best indices of a hospital's scientific standing. The autopsy today is the end result of an honorable heritage, briefly traced here by Dr. Spiro.

Medical practice rests in part upon a knowledge of normal and pathologic anatomy. The accumulation of precise, detailed anatomic data has been a difficult, often perilous task.

Postmortem study developed under the impetus of two factors; (a) man's quest for facts concerning his body and its relationship to disease, and (b) the need to provide a legal explanation for unexpected death.

The word *autopsy* today means a postmortem examination. In the third century B. C., however, "autopsia" referred to observations made by a physician upon a living patient, as contrasted with "historia," the story of the case, supplied by the patient. Modern usage has combined the two Greek words, "autos" self, and "opis" to look at, in *autopsy;* literally to look at one's own necropsy.[1]

Those who first sought knowledge of man's structure realized that studying the outer surface of man was of limited value. It was necessary to penetrate the skin to examine underlying structures. The pain of incising the skin and the consequent need for rapid examination eliminated the use of living persons. A lifeless human feels no pain, and could be the instrument to obtain information about man's structure: a simple plan, but difficult of execution. Then, as now, there existed a strong reluctance to examine a body in detail after death.

ANTIQUITY

Clues to ancient attitudes towards postmortem handling of the human body are found in such varied places as the Pyramids, Etruscan tombs, Peruvian mummies, and the Cuneiform library at Ninevah. The ancient Egyptians considered human dissection an offense against the dead. Bodies were embalmed in preparation for a life beyond the grave. The embalmers were members of guilds which thrived until the rise of the Roman Empire. Fees for services ranged up to one thousand dollars, depending upon the elaborateness of the embalming. The procedure follows.

A technician made the initial incision into the abdominal cavity. Having "offended" the body, he sought refuge from the onlookers who might stone him. Additional technicians eviscerated the abdomen, preserving the organs in clay receptacles. The brain was then torn out of the calvarium via the nares, perhaps presaging today's per-nasal prefrontal leukotomy. The abdominal and skull cavities were filled with spices and the body immersed in saline

for seventy days. A gum coating was applied to the body which was wrapped in cloth and placed in a sarcophagus. The body was buried together with its viscera contained in jars.[2]

Presumably, the embalmers made gross observations on the unusual location and appearance of organs. What they observed may be surmised from a study of recently discovered specimens. Archeologic investigation has unearthed mummies having fractures and appendiceal inflammation. Early Egyptians, accustomed to fibrous tough food, had few dental cavities. Their descendants, enjoying luxury and soft food, had many.

Observations made by the embalmers during preservation of the dead were rarely transmitted to the elite priest-physicians, for class barriers were rigid.[3]

Certain phases of anatomy and pathology were known as early as 5000 B. C. The earliest medical record, The Edwin Smith Surgical Papyrus, contains comment on the diffusion of blood from the heart to the body.[4]

The Hebrew religion required critical inspection of animals intended for human consumption. This provided an indirect source for postmortem study. Records of early Hebrew medicine found in the Talmud, contain discussion of vertebrate anatomy. The brain membranes, respiratory tract, esophagus and reproductive organs are mentioned. Hyperemia, caseous degeneration, hepatic necrosis and cirrhosis, atrophy, organ agenesis, and intestinal worm infestation are noted.

The heart was known to be essential for life. Blood was considered a "vital" agent, and breathing was likened to burning. Saliva and stomach contractions were known to affect food. Acquaintance with tuberculosis is suggested by remarks about pleurisy and effusion Inflation of the lungs of the dead and submersion in water were further utilized to evaluate lung pathology.

The Hebrews reoriented a portion of the knowledge of anatomy and pathology learned from animal study to their understanding of the structure of man. A Hebrew was obliged to isolate himself for seven days after autopsying a human.[5]

Among other people of antiquity, scant necropsy study is recorded. The Assyrians offer no records suggesting activity in this field. Fully one thousand years B. C., Susruta, the famous Indian surgeon who used wines to produce pain insensibility, advocated dissection of the dead for the training of a surgeon.

The Homeric poets suggest certain familiarity with study of the body by the occasional detailed descriptions in their writings. This knowledge appears greater than could be gleaned from animal dissection or observation of human wounds. The bodies of enemies fallen in battle may have been examined. Postmortem study was neglected during the Roman Empire.[3]

The natural philosophers of southern Italy were responsible for the inception of Medical Schools. During the fifth century B. C. Alcmaeon recognized the brain as the organ of the mind, described the optic nerve, and refuted the belief that sperm came from the spinal cord.[6] Hippocrates knew little else than exterior of the body although he recognized the importance of anatomy.

Aristotle, who was familiar with the postmortem studies of Alcmaeon, was unfamiliar with a human kidney or uterus, and did not even know the difference between a vein and an artery.[6]

Celsus lived at the beginning of the Christian era. He believed it necessary to perform autopsy studies of humans. In *De Medicina* he wrote of the structure of the ear canals, and cranial sutures. Some autopsy study was being done in Rome in early Christian times.

Claudius Galen, working in a world reluctant to admit his brilliance, shaped the course of postmortem study for thirteen centuries. He studied the bodies of apes, dogs, pigs, and oxen, making careful observations of each species examined. Galen assumed that his anatomic findings in animals were valid in humans. This error precipitated thirteen centuries of anatomic confusion. Thus, for centuries it was believed that the human breastbone was

segmented like that of the ape, the liver multilobed as in the hog, the hip bones flared as in the dog, and the uterus composed of two long horns. Galen dissected and studied a few human bodies and bones unearthed in graveyards by stones and floods. He recognized that veins carried fluid whose flow was directed by valves and he believed chyle was transported to the liver by veins and lymphatics.[2]

A recently discovered catacomb in Rome contains an early 4th century fresco depicting a medical class gathered about a "lecturer," who demonstrates with a pointer, parts of an opened cadaver. Scattered individuals attempted to further the acceptance of postmortem study. After the 6th century, autopsies were occasionally performed in Byzantium to learn the cause of plagues.

The Spanish friar Villanova expounded the value of autopsies in his *System of Philosophy*. After Villanova's death, Frederic II ordered that a human body be dissected at Salerno every five years, and that only those surgeons who showed evidence of having studied the body could practice.[3] However, these men do not typify thought of their times; and in the main, postmortem study languished from the death of Galen until the middle ages.

THE MIDDLE AGES

POSTMORTEM dissection was initiated at Siena in 1348; Montpellier, 1366; Venice, 1368; and Florence, 1388. Beginning in 1478, the faculty of the University of Paris was required to perform four necropsies annually. The Anatomy Theatre was erected at Padua in the mid-fifteenth century, and postmortem study was active there from the sixteenth century.

Records of Antonio Benieveni, an active general practitioner, published by his brother, correlate the clinical picture and postmortem findings in cases of cholelithiasis, mesenteric abscess, mesenteric thrombosis, pyloric cancer, and tuberculosis. Benieveni was the first physician to request permission from a family for an autopsy.

The first true student of anatomy was Mondino de Luzzi, at the University of Bologna. Mundinus published *Anathomie* in 1516, a textbook of anatomy which was the standard student reference for three centuries. The material was based upon human dissection. An attempt to correlate the structure and function of portions of the body, for instance, the relative size of the uterus in multipara and virgins, is present throughout. Mundinus's book stimulated autopsy study significantly and specimens for study became scarce. Body stealing for postmortem study was begun in 1319 by four students who were ultimately seized and prosecuted for defiling the dead.

In the 16th century, artists turned to dissection as a means for improving the accuracy of their work. New terms of anatomy were being introduced. The autopsy was beginning to become more common.

THE Belgian anatomist Vesalius initiated a renaissance in the science of postmortem study. He became Professor of Anatomy at Padua, shortly after being graduated from medical school. He set aside the traditional surgeon-demonstrator, and did the dissecting himself. In 1453, after six years of extensive investigation of human and other bodies, he published his masterpiece, *Tabulae Anatomicae*, which long remained the key to anatomy. Many of the anatomic charts were drawn by Vesalius himself. Vesalius best served the medical world by dissipating some of the ironclad Galenical bonds of thought which had restricted all contrary opinion: a very difficult task. Its enormity is indicated by the fact that though Vesalius had adequately refuted Galen's belief that man had flared hip bones like the dog, the clerics and physicians of the day resolved this contradiction by saying that man had changed his body configuration by wearing tight trousers, a mode of dress initiated subsequent to the time of Galen.[2]

In spite of popular blind faith, such false concepts as the male having one less rib than the female (Adam's missing rib), the segmented sternum, the dual biliary tree, and the multilobed liver all developed by Galen and faith-

fully nurtured by his followers, were interred by Vesalius. He prepared the first skeleton for a medical school.

The interval of the 16th and 17th century was highlighted by several workers in various fields. A Freiberg physician, Von Grafenburg, was the forerunner of the subsequent notable German school of pathologists. During the late 16th century he performed autopsies on his patients, systematically recording his findings.

Jean Fernel published at Paris, in 1554, *Medicina,* a book on the pathogenesis of disease. His description of "iliac passion" may be the first reference to inflammation of appendix.[9]

By act of Parliament in England in 1540, it was decreed that bodies of executed criminals be given each year to the Barber-Surgeons for dissection. Twenty-five years later, Queen Elizabeth donated to the College of Physicians of London the bodies of four executed felons for dissection.

RIVA, a Papal physician, founded a society for the study of pathologic anatomy, and also a museum for specimens. Case reports were received from such prominent members as Malphigi, Glisson, Bartholin, and Sylvius, men whose very names suggest significant observations. Rugsh founded the morbid anatomy museum at Leyden in 1701. Shortly afterwards, John Hunter inspired the museums of pathology and anatomy at Glasgow and at the Royal College of Surgeons in London.[7]

The Company of Barber Surgeons and College of Physicians began to perform dissections publicly in the 17th century. Three or four times annually, bodies of three criminals would be dissected to demonstrate the muscles, skeleton, vascular tree, and viscera.

Leutand published a record of 1200 postmortem studies done by him at Versailles. He was the first to catalogue autopsy findings by the organ involved instead of by leading symptoms.[3]

Two technics introduced at this time gradually enlarged the scope of postmortem study. Leeuwenhoek began to observe bacteria, and Bichat was able to preserve tissue obtained at postmortem for future microscope study.

Charles II in England decreed that dissection after death be added to the list of penalties for a criminal convicted of murder.

Morgagni studied at Bologna and later became professor of medicine at Padua. He is considered by many the father of pathology. Morgagni authored *De Sedibus at Causis Morborum per Anatomen Indigatis,* which stressed clinical pathological correlation diseases. Particular comment was made concerning the heart and its valves, the pericardium, and the aorta. Morgagni was interested in angina pectoris, and wrote much about the symptoms and corresponding anatomic findings.

RECENT TIMES

POSTMORTEM study in England was carried out by practicing physicians. The names of a few leaders of medical progress in England active at this time, Bright, Hodgkin, Graves, and Addison, suggest the quality and nature of the postmortem study being done.

John Hunter performed postmortem study and prepared specimens to begin the pathologic museum at Glasgow. As a sequel to his work, his nephew, Matthew Baillie published *The Morbid Anatomy of Some of the Most Important Parts of the Human Body.*

In 1832, the English Parliament passed the Warburton Anatomy Act requiring a license for the study of anatomy. The dissection of criminal bodies was no longer necessary, since the bodies of unclaimed paupers might be dissected.

In Austria and Germany, legislation permitting postmortem study of most dead bodies was enacted in the nineteenth century This became relatively commonplace thereafter. Pathology became a recognized area of specialization for physicians.

In 1874, the Allgemeines Krankenhaus was founded in Vienna, and provided in time a rich source for study of patients. Frank, a professor at the hospital, initiated the teaching museum of pathologic anatomy.

Rokitansky, a volunteer assistant in the hospital in 1828, was elevated in 1844 to the Professorship of Anatomy at Vienna and hospital

pathologist. He performed 40,000 autopsies, and published his monumental *Handbuch der Pathologishen Anatomie*. His special studies included acute yellow hepatic atrophy, goiter, arterial diseases, perforation of gastric ulcers, and cardiac anomalies. By 1856, more than 1,400 autopsies were done annually in this department.

Rokitansky was followed by Virchow, a pupil of Muller. He published material stating his concept of cellular pathology, and studied thrombosis, embolism, leukemia, and amyloid disease in particular.[7]

THE NEW WORLD

THE initial protocol of the New World comes from San Domingo. Here, Oviedo was called to see Siamese twins in July, 1553. Their bodies were fused from the umbilicus to the breast level, each body having two arms. Considerable discussion ensued concerning the number of souls in the two bodies. A double baptism was performed. The children died after eight days and an autopsy was done by Camacho to determine the number of souls within the bodies. He records finding two kidneys, separate intestinal tracts, and hearts within each body, thus indicating the wisdom of the dual baptism and the general independence of the two bodies.[11]

Champlain recorded postmortem studies in his *Voyages*. He carefully described scurvy with its bleeding from mucous membranes, painful joints, edema, and commented upon the beneficial effects of sunshine.[2]

The first medicolegal autopsy in the colonies was done in 1691 on the body of Governor Slaughter of New York. Only four times previously had other autopsies been performed.[13]

Postmortem study became more common on the American continent in the 19th century. The Constitution of the Medical Society of Augusta which states that, "No physician is to attend a coroner's inquest unless legally summoned and then is to charge $10-20;" attests to the incipient acceptance of the autopsy. In the initial issue of the *Southern Medical and Surgical Journal* (1836) is a report of a postmortem study of a case of vertebral fracture.[4]

The first public announcement in the United States of a course in dissection appeared in the New York *Weekly Postboy*, 1752. A course of one month's length with dissection of a dead human body was offered to aid surgeons in preparing for the care of patients.[2] In Philadelphia, William Shippen, Jr. conducted the first successful course of anatomic dissection in the United States. Shippen was subsequently made Surgeon General of the Army during the Revolutionary War.

The first course in pathologic anatomy in this country was offered by Samuel D. Gross at the Medical School in Cincinnati and four years later he published the first text on this subject in the United States.[8]

During the 18th century, a number of schools began to offer courses in anatomy, inadvertently making grave robbing a profitable business. In the nineteenth century, an attempt was made to provide bodies for dissection without resort to grave robbing. The first anatomy law in the United States was in Massachusetts. It permitted the coroner to dispose of the bodies of men slain dueling, by the requirement that they be buried "with a coffin with a stake driven through the body . . . or to deliver the body to any surgeon or surgeons to be anatomized." In 1831, the same state passed a law for the dissection of "deceased persons required to be buried at public expense." This type of legislation slowly received acceptance in the United States.

THE TWENTIETH CENTURY

POSTMORTEM study is an accepted practice in modern hospitals. In this country, early efforts to stress the importance of pathology in terms of better care of patients were made by Welch and MacCallum at Johns Hopkins, and by Karsner at Western Reserve University.

Modern cardiovascular surgery depends heavily upon the early postmortem studies of Maude Abbott. Subsequent physiologic study of congenital defects has permitted an effec-

tive approach to solution in many instances. This work may represent the brightest dividend from postmortem study in the first half of the twentieth century.

MEDICO-LEGAL AUTOPSY

THE need to furnish adequate explanation for an unexpected death has influenced public acceptance of the autopsy. The rise of legal medicine with its relationships to the postmortem investigation has been most marked since the seventeenth century. A number of earlier references, however, can be found. Krumbhaar quoted Gru as saying that Sigurd Iorsalfar, in the eleventh century, had one of his men (suspected of being poisoned) autopsied.[3] In the Sung dynasty of China (1241-53), there existed a position analagous to that of coroner or medical examiner. The *Hsi Yan Lu* (Record of the Washing Away Wrongs) contains material relative to a medico-legal study of the dead body. It is stated that a relative who has committed murder will be detected by the way his blood sinks into the victim's bone. Wounds should be examined, and detailed instructions for the examination of the body are provided.[15]

Since 1289, the Provost of Paris must name a physician to view the corpse in any case of doubtful death. Such activity was not of great early consequence, for the first judicial autopsy was not performed until the time of Paré, several centuries later.

Development of the medico-legal autopsy was early assisted by legislation for the study of the dead body. In the early 16th century, Charles V authorized the court to summon a physician as an expert witness in medico-legal cases. Though the expert medical legal witness was sponsored by the court, training of this type of witness was denied, for in deference to public hesitance towards the postmortem examination, the autopsy was not authorized. The Republic of Lucca in 1699 granted permission to study the bodies of moribund consumptives, although popular opposition towards postmortem investigation soon restricted this legislation. An Austrian decree in 1796 created a "Totenbeschauer" to act when the attending doctor failed to assert the cause of death of his patient. The same task fell to a civilian physician in Holland, and a police physician in Denmark. Spain, Russia, and Turkey in 1875 created the appointment for a state physician to study the bodies in cases of undetermined death. Germany, in the nineteenth century, advanced to the point of making obligatory inspection and examination of the dead body.[2] The autopsies so performed supplied the museums and schools of central Europe with excellent teaching material.

Italians were pioneers in medico-legal study. Codronchi, in *De Morbis Veneficis* (1595) noted the effect of a number of poisons upon the body. Zacchia edited *Quaestiones Medico-Legales*, 1621-35, which in the style of modern legal writing, contained court discussions supplemented by citation of the case in reference with the court decision. This method for presenting the subject made the text popular for many years. Melchior Sibaz published a treatise on the postmortem signs of virginity.

IN GERMANY, a firm basis for postmortem medico-legal study was initiated by Casper of Berlin, who established a wide reputation for his study of actuarial science. Casper also published a study on judicial autopsies and culminated his work in 1856 with a *Practical Handbook of Legal Medicine*, emphasizing his concepts about the legal aspects of autopsies. Johann Bonn described a method for study of fatal wounds, insisting upon complete opening of the body with inspection of all the contents and cavities.

The most important medico-legal product of the seventeenth century was the observation by Swammerdam that fetal lungs will float on water if they have once been inflated by breathing. Considerable reliance has been placed upon this test until the present period.

Fodere wrote a medical jurisprudence text which was published in 1798 and became the standard reference book in France during the early nineteenth century. Lewin compiled important case studies in his handbook of legal medicine, for a long time the popular text of

reference for the law enforcing agencies. Lombrose, in 1865 wrote *Medicina Legale Del Cadavera*, insisting on the use of the experimental approach in legal medicine.[9]

THE CORONER

THE medico-legal autopsy seems to have originated in the English-speaking countries with the creation of the position of Coronator in the time of Alfred the Great. The existence of this functionary is found in the recordings of the era of Edward I. The coroner was to protect, among other things, the Crown's privileges against the County or Sheriff. In cases of suspicious death, it was therefore necessary for him to determine the cause of death, thus preserving the Crown's right to material property of the deceased. The significance of the participation of the Coroner has markedly lessened, until now he directs that an autopsy be performed in situations of unexpected death. Early English medico-legal treatises were written by Beck, 1823, Issac Ray, 1839, and Guy, 1844.[3] The title "coroner" comes, of course, from the Latin word for crown.

In the United States a situation similar to England's plan has existed, perhaps with occasional footballing of the position of coroner by politicians. Massachusetts, in 1877, replaced the politically inspired coroner with a scientifically trained medical examiner and a few other states followed this lead.[3]

Since the middle of the nineteenth century, many governments have exercised a favorable attitude toward the medico-legal phase of the postmortem study. In some countries, institutes of forensic medicine, which combine the knowledge of the medical school academicians with the practical technics of the law enforcing agencies, represent the modern attempt to create the most efficacious system for the conduct of the postmortem medico-legal study.

59 Fremont Street

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Obituaries • • •

DR. A. MAURICE CURTIS

On January 2, 1958, Dr. A. Maurice Curtis died at the Barnert Hospital. Born in Chicago in 1890, Dr. Curtis was graduated in 1914 from the medical school of Howard University. Prior to that he won a baccalaureate degree at the University of Michigan. Following his internship, he moved in 1917 to Paterson and here he remained. He served the people of Passaic County for 40 years. He was active in the county tuberculosis society, and in the Passaic County Grand Jurors' Association.

DR. HENRY E. DWYER

Dr. Henry E. Dwyer of Passaic died on November 9, 1957, at the age of 67. A native of Passaic, he was graduated in 1914 from Bellevue and served in World War I as a surgeon in the 78th Division in France. He became affiliated with St. Mary's Hospital in Passaic and passed through all the ranks, becoming, eventually, chief of Surgery there. He was, for a decade, City Physician, and later became Chief Health Officer of Passaic. Dr. Dwyer also headed the County Mosquito Commission. Dr. Dwyer, a Fellow of the American College of Surgeons, was active in the affairs of the Passaic County Medical Society.

DR. ELLEN C. POTTER

New Jersey lost one of its truly great ladies on February 8, 1958 with the death that day of Ellen C. Potter. Born in Connecticut in 1871, she was graduated in 1903 from the Women's Medical College in Philadelphia. From the beginning she plunged herself into welfare work. She entered the State Welfare Department as a clinic doctor and rose so rapidly that by 1919 she had become Commissioner of Welfare for the Commonwealth of Pennsylvania—the first woman in the country to hold that kind of post. She remained 8 years, when she left to become Deputy Commissioner for Medicine in our State Department of Institutions and Agencies.

Dr. Potter has been identified with New Jersey welfare programs since 1927. She was once Superintendent at the State Home for Girls in Trenton. She also had a term as president of the Women's Medical College of Philadelphia. In 1954 the women physicians of the nation named Ellen Potter as "Woman of the Year." The Trenton Council of Womens' Clubs the following year gave Dr. Potter a similar honor—Trenton Woman of the Year. She was the laureate of the Terry Memorial Award in 1949—an award of the American Public Welfare Association.

In our Department of Institutions and Agencies she served under Commissioners Ellis, Bates and Tramburg. She was a vigorous force for improved welfare activities on all fronts—particularly health and child welfare. She belonged to a dozen eminent national bodies in various fields of social work, penology, health and welfare. She was a long-term member of, and more recently an emeritus member of the Mercer County Medical Society. Having no immediate family of her own, she made us all her children. There is probably no facet of human welfare work in our state that was not touched by her hand and her mind and her heart.

DR. GEORGE K. TWEDDEL

On January 17, 1958, Dr. George K. Tweddel, Sr., died in Paterson. Born in Philadelphia, Dr. Tweddel earned his baccalaureate degree at Princeton in 1912 and his M.D. at the University of Pennsylvania in 1916. After interning, he entered the Army and saw foreign service during World War I. He then came to Paterson where he entered private practice. He was a pioneer in specialization in dermatology, and he worked in that field at the Paterson General Hospital, rising through all grades to become chief of dermatology and president of the medical board of that hospital. Dr. Tweddel was a Fellow of the American Academy of Dermatology and was active in the affairs of the Passaic County Medical Society.

Announcements • • •

Course in Electrocardiography

Starting on March 24, 1958, a course in electrocardiography is announced for Mondays at 4 p.m. Classes will be held at East Orange General Hospital, under the auspices of the Seton Hall College of Medicine and Dentistry. The course runs for five consecutive Mondays. For details, write to Seton Hall College, 31 Clinton Street, Newark 2, New Jersey.

Gastro-Enterological Meeting

A gastro-enterological treat is promised for gastro-enterologists and their friends on April 9. This is the occasion of the dinner meeting of the N. J. Gastro-Enterological Society and a balanced banquet will be served at the Essex House, Lincoln Park, Newark at 7 p.m. on that Wednesday. In addition to the physical meal there will be an intellectual meal—a symposium on the human esophagus. For details write to Dr. A. I. Friedman at 405 State St., Hackensack.

Venereal Disease Symposium

A colloquium on recent V.D. advances is scheduled for Philadelphia May 12 and 13. For details write to the Sheraton Hotel in Philadelphia. Following this colloquium will be a 2 day intensive course in diagnosis and treatment.

Course in Pediatric Oncology

General Practitioners, pediatricians and health officers will be interested in an intensive full-time 3-day course covering the diagnosis and management of benign and malignant tumors of children. The course is given at Memorial Hospital, East 68 Street, New York City and includes ward rounds, seminars, and clinical demonstrations. Tuition is $35. The class is limited. For more details write to Director of Pediatrics at the Memorial Center, 444 East 68 Street, New York, N. Y.

Roster of Carcinogenic Compounds

The U. S. Government Printing Office now has available a unique survey of compounds (almost a thousand of them) which have been tested for carcinogenic activity. Copies are available at $3.50 each from Superintendent of Documents, Government Printing Office, Washington 25, D. C. Ask for "Survey of Compounds Tested for Carcinogenic Activity."

Definition of Ophthalmologist

In view of public confusion on the subject, doctors might be interested in stocking in their waiting rooms, a pamphlet entitled "What is an Ophthalmologist?" This distinguishes in simple terms, without bias, the oculist, the optometrist, the optimist, the ophthalmologist and the optician. Copies are obtained from the National Medical Foundation for Eye Care at 250 West 57 Street, New York 19, N. Y.

County Society Reports • • •

Atlantic

The December meeting of the *Medical Society of Atlantic County* was held on December 13, 1957 at the Children's Seashore House. The meeting was called to order by the President, Dr. Levi Walker.

No scientific program was scheduled for this meeting because of the Christmas Party following the business meeting. Dr. Molitch gave a report of the Censorship Committee. Dr. Alfred Rosenblatt was promoted from associate to regular member. He was granted leave of absence for military service. Dr. S. Ronald Kline was made an associate member and placed on leave of absence for military service. Several new applications were relayed to the Censorship Committee for consideration.

Dr. Gleason reported for the Insurance Committee and reminded us that many Blue Cross checks had not been returned to his office. Dr. Gleason also mentioned an insurance policy which might be of benefit to members of the Society. After a short discussion he was asked to investigate the matter.

A motion was passed instructing the secretary to send a letter to the American Medical Association inviting them to hold the 1963 National Convention in Atlantic City.

A letter was read from Mrs. Baxter Timberlake thanking the Society for a gift made to the Atlantic City Hospital Building Fund in honor of the late Dr. Baxter Timberlake.

A letter was read from the Atlantic - Cape May County Pharmaceutical Association concerning the possibility of reducing the cost of medication to Welfare clients. They made suggestions that the cost could be further reduced by the physicians in the county.

LEONARD B. ERBER, M.D.,
Reporter.

Bergen

The regular meeting of the *Bergen County Medical Society* was held Tuesday, January 14, 1958.

The following new regular members received their member certificates and wallet identification cards: William N. Burke, Jerome Ferber, Sylvia K. Fried, Milton Greenberg, Alfred F. Granatelli, Harold R. Hanson and Marianne S. Ostrand.

The Chair asked the two new Associate Members to rise: Elias Lika and Pauline Pellicano Territo.

The Secretary read the following names which had been approved by the Executive Committee for election:

To Regular by Transfer: Gerald L. Eastman, Michael J. Romano, Howard H. Schlossman.

To Courtesy: Lester Fox, Arthur A. Goldfarb, David M. Weeks.

To Associate: Frank A. Franklin, Valentino V. Sica.

The Secretary was instructed to cast one ballot for the election of these applicants.

The B.C.M.S. as of December 31, 1957, became the second largest Society in the State with 570 paid members. Hudson County is now the third with 559. Hudson County has 38 exempt members giving them a total voting membership of 597 whereas Bergen County's 26 exempt members makes a total of 596 voting members. Both counties are apportioned 40 delegates to the 1958 Annual Meeting, an increase of 3 over last year for this Society.

Dr. Harriet Knox is today celebrating her eighty-fifth birthday. When Dr. Knox appeared at the meeting, the members rose applauding and spontaneously joined in singing "Happy Birthday to You."

Dr. W. H. Johnson reported that legal negotiations in connection with the pending purchase of the Teaneck property were being somewhat delayed. The following resolution was then adopted:

Resolved: That the resolution adopted by the Bergen County Medical Society on October 8, 1957, providing for payment by the members of an assessment of $75 each with the 1958 dues due January 1, 1958, be amended to provide that the date for the payment of said assessment shall be such date after January 1, 1958, as the Executive Committee or the members of the Society may hereafter determine.

Dr. Heller called attention to the small gummed labels which had been placed on the chairs in the auditorium. These announced the Emergency Medical Service recently established which provides for a single telephone number—DI 2-4357 (the four digits spell the letters H-E-L-P on the dial). This number may be used by any resident of Bergen County to call one of the 150 doctors who have volunteered to serve on one of the eleven panels covering all 70 municipalities in the county.

Dr. John Olpp reported on the recent action of Bergen Pines Hospital and Valley Hospital in formally registering opposition to HR 9476—The Forand Bill. He quoted a letter from the American Medical Association's Washington Office, expressing appreciation for the Bergen Pines letter. He said that these informational communications were valuable in discussing pending legislation with

Washington legislators. Dr. Olpp also suggested that the members write to Honorable Frank C. Osmers, Jr., Representative from Bergen County, expressing their appreciation for his recent speech on the floor of the House in favor of the Jenkins-Keogh Bill.

Dr. Fitzpatrick introduced Dr. William Roe, chairman of the Scientific Program Committee who in turn, asked Dr. John T. Flynn to present the speaker of the evening. Dr. Flynn introduced Dr. Walter Newman, Asst. Chief of Cardiology, Veterans Administration Hospital, Bronx, N. Y. and Lecturer in Medicine, New York University School of Medicine. Dr. Newman discussed the differentiation of angina pectoris, the prodromal syndrome, and myocardial infarctions. He stressed the fact that these differentiations can be made largely from case histories and that it is very important in the management of coronary heart disease. At the conclusion of his talk, many aspects of treatment brought out the fact that the studies today are far from conclusive but that they have progressed to the point where continued work along these lines is indicated.

There being no additional business, the meeting was adjourned at 10:12 p.m.

CHARLES P. CAMPBELL, M.D
Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held on January 7, 1958, at Cherry Hill Inn, with Dr. Ralph S. Wright presiding. Drs. William R. Davidson, Theodore J. DeConna and Ralph A. Skowron were welcomed into the Society by taking the membership oath and signing the register.

Dr. Elmer L. Grimes, Program Committee Chairman, requested Dr. Robert N. Bowen to present Dr. David B. Allman, President of the American Medical Association, guest speaker for the evening. Dr. Allman gave a concise talk on the development of new policies of the parent organization. He advised that the A.M.A. is cognizant of our ever-changing world and outlined how we, as physicians, must meet the challenge, particularly in the socio-economic field, and how we must guard vigilantly against the inroads towards the establishment of a Socialist state. He also informed the members about the incorporation by the A.M.A. of the research foundation which will disseminate useful research in the field of medicine. Dr. Allman's talk was followed by a question and answer period. At the conclusion of Dr. Allman's talk he was congratulated by Dr. Wright as the first New Jersey physician to become President of the A.M.A.

The regular monthly meeting of the *Camden County Medical Society* was held on February 4, 1958, at Cherry Hill Inn, with President Ralph S. Wright, presiding.

The following new members were introduced to the Society after taking the membership oath and signing the Register: Drs. Francis E. Barse, David E. Bullock, Jr., George E. Covintree, Leonard H. Doloff, and Gordon R. Field.

Dr. William T. Read, Chairman of the Executive Committee, advised the members of the Bar Association Dinner being held March 25 and that members are invited to hear C. Joseph Stetler, Director of the Law Department of the A.M.A. Dr. Read stressed the point that we are making every endeavor to increase our relationships with the Bar Association and urged as many members as possible to attend this meeting.

Dr. Wright announced the action taken by the Executive Committee in the dropping of four members for non-payment of dues.

The scientific program was presented by the staff of Our Lady of Lourdes Hospital under the chairmanship of Dr. Robert L. Breckenridge. The following were presented: "Sheehan's Syndrome," Dr. Vincent T. McDermott, Dr. Edward Mazur; "Thalassemia Major," Dr. Anthony J. Pepici; "Spontaneous Rupture of the Spleen," Dr. Edgar T. Gibson; "Adrenal Cyst," Dr. Reuben Block and Dr. Chauncey K. McGeorge; "Placenta Accreta," Dr. James R. Herron.

EUGENE H. KAIN, M.D.
Reporter

Middlesex

The January 15, 1958 meeting of the *Middlesex County Medical Society* was called to order by the Vice-President, Dr. George J. Kohut at the Roosevelt Hospital, Metuchen, at 9:00 p.m. The minutes of the December meeting were approved as read.

Applications for membership were approved and voted on as follows:

To Two-years Associate membership: Dr. Earle N. Rothbell, Colonia; Dr. E. Nicholas Sargeant, Perth Amboy.

To Regular membership from Associate membership: Dr. Edward S. Sherwood, New Brunswick; Dr. Charlotte Choper Weiss, New Brunswick.

Dr. C. H. Calvin, Chairman of the Constitution and By-Laws Committee, stated that many changes were made in the proposed revised constitution and by-laws by the Board of Trustees. A copy of the changes will be sent to each member of the Society and will be voted upon in the near future.

Dr. George J. Kohut reported on the deaths of Drs. N. N. Forney, Sr. and William Klein.

Dr. Moolten introduced Mr. Arnold Rosenthal, C.P.A., of New Brunswick, N. J., who spoke on the subject "Medical Tax Problems and Investments." He answered the many questions put to him by the members of the Society.

The meeting was adjourned and collation was served.

R. G. MATFLERD, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held in joint sponsorship with the Passaic County Heart Association on Tuesday, January 21, 1958 at 9:00 p.m. at the St. Joseph Hospital in Paterson. This was in memory of the late Dr. Meyer Notkin, a devoted member of the Medical Society and the Heart Association, and it was the second memorial lecture in his name.

Dr. Samuel C. Yachnin, President of the Medical Society, welcomed the group, explained the functions of the Heart Association and commended it for the good work it has done in the past. He said the Society enthusiastically supports it.

A short business session followed and one physician was elected to Active membership: C. June Moore Cardulo of Pompton Plains.

The President then asked the Secretary to read the resolutions on the recent death of two members of the Society, Dr. Henry E. Dwyer of Passaic and Dr. A. Maurice Curtis of Paterson.

Dr. Moriarty read proposed changes to the Constitution and By-Laws, which changes will appear in the February *Bulletin*, and will be voted upon at the February meeting.

Dr. Yachnin then introduced the President of the Passaic County Heart Association, Mr. Edward D. Rohrbach, who said a few words of greeting.

The meeting was then turned over to Dr. Gordon W. Howe, Program Chairman of the Passaic County Heart Association. He explained the numerous activities of the Heart Association and its various programs, including the Passaic County Cardiac Work Classification Unit at the Barnert Memorial Hospital and the Cardio-Vascular Surgery Unit at the Passaic General Hospital.

He then introduced the guest speaker, Daniel S. Lukas, M.D., Director, Cardio-Pulmonary Laboratory, New York Hospital. Dr. Lukas' subject was "Clinical Physiologic Disturbances in Acquired Heart Disease."

DAVID B. LEVINE, M.D.
Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held Friday afternoon, January 17, 1958, at the Du Pont-Penns Grove Country Club. Dr. Donald McLean presented the recommendations of the American Academy of Pediatrics for immunization of infants and children against contagious diseases.

Mr. Richard I. Nevin, Executive Officer of The Medical Society of New Jersey, discussed the functions of the House of Delegates, the Judicial Council and the Executive Office of the state society.

W. L. SPROUT, M.D.
Reporter

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Psychological Disorder and Crime. By W. L. Neustatter, M.D. New York, Philosophical Library, 1957. Pp. 248. ($6.00)

In 1953 this book was published (at $4.75) by the British house of Christopher Johnson. This edition is a reprint from the same plates, the pages being, of course, identical. Dr. Neustatter is a sort of anti-psychiatry psychiatrist. Thus, he quotes with approval, a verse that teases about going to a psychiatrist: "I think what you require is a good psmackbottomist" (instead of a good psychiatrist). Or, when a patient pleads hysterical amnesia, Dr. Neustatter scorns the "credulity" of the psychiatrist who accepts such a plea as made in good faith. Such a patient, says the author "succumbs to temptation like any other law-breaker." He is gentler with psychopaths than with hysterical people, believing that "half the aggressive types of psychopaths have abnormal electroencephalograms." These people, he suggests "genuinely cannot resist their urges, for otherwise why should they incessantly get themselves into needless trouble?" (Why, indeed?).

With respect to sex offenders, Dr. Neustatter believes that the "stable, honest, reliable pervert with a good work record has a good chance of not repeating the offense." He recommends stilbesterol for perverts because, he says, this completely abolishes sexual desire. Perhaps the best example of the author's philosophy is this choice item from his chapter on juvenile delinquency: "The poor, who previously were expected to keep their places, used to accept their poverty as the nature of things. Today, many are no longer willing to do this, preferring to make money quickly . . . the growing

insistence on the rights of the underdog may produce a frame of mind in which they feel justified in taking the law into their own hands."

Next question?

HERBERT BOEHM, M.D.

Principles of Urology. By Meredith F. Campbell, M.D. Philadelphia, 1957, Saunders. Cloth. Pp. 622, 319 illustrations. ($9.50)

This book has been written to instruct the student in the fundamentals of urology, and to serve as a practical guide for the physician who is not a urologic specialist. The text includes consideration of urologic semantics with a short syllabus of common urologic terms. This section shows many of the common blunders in the use of medical terms and in the structure of medical language. A good example is the use of the word "cystoscope" as a verb, which it is not. There is a syllabus of common urologic terms with a list of Greek and Latin prefixes and suffixes with the origin and translation.

Another outstanding feature of this book is the series of questions. The questions are thought-provoking and give the student an excellent review of the subject. The first four chapters deal with methods of diagnosis. The remaining chapters treat urologic entities on the basis of etiology and pathogenesis. Minor urologic diagnostic procedures and minor operative procedures are described. The only major procedure described in detail is the Torek orchiopexy. There is a misprint in the book on page 485 where the size of the prostate gland is given as 50 milligrams instead of 50 Grams. The x-ray reproductions and the illustrations are well done. This book is a valuable addition to the library of any student of urology.

THEODORE B. DUNN, M.D.

Textbook of Pathology with Clinical Applications. Stanley L. Robbins, M.D. Saunders, Philadelphia 1957, pp. 1351, illustrations 933. ($18.00)

Too often pathology is considered a "dead-house" subject of interest only to the specialist in the field. That pathology can be presented in living terms is ably demonstrated by this recently published textbook. Writing in a clear, lucid, readable style, the author builds one basic concept upon another in logical sequence and eventually relates a given topic to the living patient. Thus emphasis is placed on the impact of disease upon function rather than upon what disease does to individual tissues, although this latter aspect is not neglected.

Inevitably a textbook of pathology must deal with disease in terms of morphologic alteration. The first third of the book is primarily devoted to this phase of the subject and there is a certain indefinable sparkle and crispness of style that keeps the reader interested and alert. The later chapters apply these fundamentals to individual organs and systems. In the discussion of systemic diseases, the author attempts to present in its entirety the clinical and anatomic aspects of the disease under consideration rather than present the material piecemeal under each organ involved.

The morphologic descriptions are presented in bold type for ready reference. The liberal use of technically excellent and pertinent illustrations supplement the text throughout. An unusual feature worthy of note are the brief descriptive comments relating to the content of each refcrence given in the bibliography at the end of every chapter. This enables the interested reader to choose those references most likely to suit his particular purpose. This textbook will serve admirably as a broad source of information for the interested student of medicine regardless of his field of specialization.

GEORGE L. ERDMAN, M.D.

Stedman's Medical Dictionary. Edited by N. B. Taylor, M.D. Ed. 19. Baltimore 1957. Williams and Wilkins. Pp. 1656. ($12.50)

It is a relief to find a medical dictionary that lists Dhobie's itch under "D" and Volkmann's contracture under "V" instead of placing them under the second word. This fat volume is the 19th edition. In addition to the traditional A to Z dictionary it is chock full of special features. It includes a monograph on medical etymology with a roster of the common prefixes and suffixes. The word list includes dental, veterinary, pharmaceutical and even botanical terms. The men behind the eponyms are given compact but interesting biographical treatment. There are tables of weights, measures, temperature conversions, proof-readers' symbols, pathogenic organisms, foramina, fossae and fasciae. Two dozen colored plates cover a variety of pictures from blood slides in anemias to surface areas corresponding to spinal cord segments. One may quarrel with some of the definitions. (Really, Dr. Taylor there is no such thing as an anxiety psychosis! And I suppose doctors in other specialties can find similar errors). But no work of man is ever perfect. This is a solid and well-fashioned tool of medical talk, medical writing and even medical thinking.

HENRY A. DAVIDSON, M.D.

Dimensions of the Human Figure. By Lloyd W. Sahley. Pp. 36. Cleveland, Ohio. 1957. Cleveland Designers and Consultants, Shaker Square, Cleveland. ($1.00)

Physicians sometimes need to know the average range of a human measurement—as, for example, the height of the eye above ground in a squatting position, or the linear distance between the pupils. Industrial designers have more need for data of this sort, and for them this unusual brochure is expressly designed. With the aid of Dr. William E. Neville of Cleveland, Mr. Sahley has developed some 50 charts showing dimensions of the human figure, male and female, in a variety of movements and postures. Here one can learn, for example, the pivot radius of the forearm, or the circumference of the biceps (12½ inches in men and 10¼ in women). Figures are given both in centimeters and in inches. And a mean, deviation and range are included when appropriate. For the orthopedist or other physician who needs such data, this booklet is unique.

VICTOR HUBERMAN, M.D.

Fear: Contagion and Conquest. By James C. Moloney, M.D. New York, 1957. The Philosophical Library. Pp. 140. ($3.75)

It is Dr. Moloney's thesis that fear is contagious to the point where a mother can transmit a sense of tension to her baby. A relaxed "motherly mother" is an essential to a neurosis-free adult life. The book includes a contrasting study of the mental hygiene of the Okinawans and the Japanese (with a conclusion that favors the Okinawans). Also reviewed is the mental hygiene effect of the return of Jewish families to Israel with, Dr. Moloney believes, marked improvement in the mental health of the children. Many psychiatrists—possibly most of us—would think that Dr. Moloney is over-enchanted by his thesis. But he writes an interesting book. No family doctor or psychiatrist needs this book in his practice; but it is a valuable source of thought-provoking ideas for lectures, self-communion and mellow conversation.

ABRAHAM LEFF, M.D.

Orthopedics for the General Practitioner. William Kenney, M.D. and C. B. Larson, M.D. St. Louis 1957. Mosby. Pp. 412 with 180 illustrations. ($11.50)

The family doctor is supposed to know everything about everything. So the current flood of specialty books for GP's is much needed. Kenney and Larson here mould a book to meet the needs of the family doctor. You don't have to read it all to find the point you need. There is special material on orthopedic problems in children. The major points are each discussed. It is easy to find what you want. Treatment is detailed. The book is lean, compact, and highly usable. The illustrations really illustrate. Any GP who has to know something about stiff neck, housemaid's knee, club foot or sprained wrist will really find this volume worth keeping at hand. The authors also touch on the major orthopedic problems. For the general practitioner, this unpretentious text is more usable than the 20-pound tomes for orthopedic surgeons.

ULYSSES M. FRANK, M.D.

Clues to Suicide. E. D. Schneidman, Ph.D. and Norman L. Farberow, Ph.D. Pp. 228. New York. McGraw-Hill. ($5.50)

Suicide is one of the ten most common causes of death in the United States. There are approximately 20,000 known suicides in the United States annually. Since there are many unrecognized suicides and since there are five attempts to each successful suicide, the importance of this problem becomes only more obvious.

"Clues to Suicide" includes contributions from psychiatrists, sociologists, a social worker and a lawyer. There is some repetition in the individual chapters of the theoretical section of the book, but it gives the reader a good survey of the psychodynamic theories of the potentially suicidal patient, his sociologic and cultural background and other factors. There is one contradiction: in the chapter on Suicide in a Catholic Country, the author refers to the widely held belief that suicide is less common among Catholics than among other religious groups. In the chapter on psychotherapy, another author says that the suicide rate is about the same for Catholics, Jews and Protestants. One of the most stimulating chapters in the theoretical part is called "The Logic of Suicide." Another outstanding chapter is the one on psychotherapy for the depressed patient. This points out the need to consider not only the intrinsic but also the extrinsic factors. A chapter of suggestions for suicide prevention gives valuable clues to early recognition of potentially suicidal patients.

The appendix is intriguing. It contains 33 genuine suicide notes matched with 33 simulated notes written by non-suicidal persons of similar age and background. The reader can check the value of this book by trying to recognize the genuine notes.

All in all *Clues to Suicide* is a well documented survey of the subject and should be helpful not only to psychiatrists but also to other physicians, psychologists, social workers and the clergy.

FELIX A. UCKO, M.D.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI March, 1958 No. 3

The Practical Value of the Tuberculin Test

By Floyd M. Feldmann, M.D., Pediatrics, Feb. 1958.

The tuberculin test has long been accepted as a simple and highly specific test for the presence of tuberculous infection, but its possibilities and its limitations tend to be overlooked. Studies done in recent years by the World Health Organization in connection with BCG vaccination programs, and observations made by the U. S. Public Health Service and others have provided valuable information, but there is still much to be learned.

Significance of Dose of Tuberculin. There is a tendency to think of the tuberculin reaction as an "all or none" phenomenon, although every pediatrician has learned that there is a wide range of tuberculin sensitivity in any group tested. Usually a tuberculin test is called positive or negative on the basis of size of reaction. If a Mantoux test is done, the indurations larger than five or six millimeters in diameter are arbitrarily called positive, but there are many smaller than this which represent some degree of sensitivity. Are these people with just a little sensitivity infected with tubercle bacilli? Undoubtedly some are but there is now good evidence that many represent a cross sensitization with other antigens. Studies now in progress may reveal the nature of the antigen or antigens able to produce some tuberculin sensitivity.

These findings give additional emphasis to an earlier study with graduated dosage of PPD which showed that in tuberculosis patients extremely small doses produce no reactors but with a gradual stepping up of the PPD strength an increasing percentage was positive until the dose of 0.0001 mg. was reached. At this point practically all persons with tuberculosis had a reaction of five millimeters or more. If the dose was further increased reactions were obtained in large numbers of children who were probably not infected. This with other studies indicates that a standard dose of 0.0001 mg. of PPD is satisfactory for most purposes.

The size of the tuberculin reaction may also be of diagnostic and prognostic significance. Recent preliminary studies (unpublished) at the Phipps Institute in Philadelphia indicate that the size of the tuberculin reaction is correlated with the probability of active tuberculosis; the bigger the reaction, the more likely it is that active disease is present.

Many observations point up the increasing usefulness of the tuberculin test to the pediatrician. The interpretations of various degrees of tuberculin sensitivity may be summarized as follows:

1. If a child has no reaction to 0.0001 mg. of PPD there is little possibility that he has a tuberculosis infection. Periodic testing, at least annually would establish the approximate time of a tuberculous infection.

2. A low degree of sensitivity with induration under five millimeters (5mm) in diameter could be the result of some other infection, or an insignificant tuberculous infection. The chance of active disease being present is extremely small.

3. With a reaction over five millimeters in size, the chances increase that active tuberculosis is now present, or will develop. Each child with such a reaction should have a thorough examination to confirm or exclude the presence of an active lesion. Most of such children will not have active lesions but will have an increased risk as they go through the ages 15 to 30, so long-term followups and periodic examinations are important.

Effect of BCG on Tuberculin Test. If a child has a positive test when first seen by the pediatrician, it will be important to know whether BCG has been given or not. The reaction may be a result of the BCG inoculation. A positive test should lead to a search for tubercle bacilli if there is reason to suspect a virulent infection. Some children do acquire serious tuberculosis disease in spite of a BCG vaccination.

Chemoprophylaxis in Tuberculin Positive Children. Isoniazid prophylactic treatment of tuberculin reactors to prevent the subsequent develop-

ment of active disease has been advocated frequently in recent years. Perhaps studies now in progress will provide more precise indications for chemoprophylaxis. At this time, however, opinion is divided and the physician will have to use his best judgment based on such things as recency of infection, the age of the child, the size of the tuberculin reaction, the presence of any lesions on x-ray, the presence of predisposing conditions such as diabetes, and the future exposure to infection. Current investigations have confirmed the considerable risk of future disease in tuberculin reactors.

Tuberculin Testing in Community Case Finding. Tuberculin testing in private practice will pay an extra dividend in community tuberculosis control by providing leads to active cases which might escape detection otherwise. If the test is positive in a young child, the infection must be recent and its source is likely to be an active case among his close associates. In older children the source of infection may be more remote. The size of the reaction is important here too. Not only are those with larger reactions much more likely to have active tuberculosis, but higher rates of tuberculosis are found among their contacts. The physician can be of help to public health authorities by insisting that all associates of tuberculin reactors receive adequate examination.

Tuberculosis Testing as an Index to Tuberculosis Prevalence. The tuberculin test is a relatively simple and inexpensive procedure for determining infection rates in groups of children and adults. If these groups are retested at intervals, trends in the rates of new infection can be detected. It is quite clear from the evidence now available that infection rates have dropped markedly in the last few years in the United States. The need for more accurate measurement of tuberculin sensitivity is increasingly apparent. The only quantitative procedure now available is the Mantoux or intradermal test. The method and material used in the test have been described often and need not be repeated.

The patch test has been used extensively because of its convenience and the fact that no needle is necessary. However, it does have serious basic limitations and is not recommended. Many attempts have been made to improve patch test results but the dose of tuberculin cannot be controlled, because of the many factors which affect absorption of tuberculin through the skin.

Tuberculin Testing Schedule. A practical age schedule for tuberculin testing must always be a compromise. It seems to be common practice to test at least once each year as long as there is no reaction, substituting annual x-ray examination if the test becomes positive. Finding even an occasional new infection should be worth the little effort it takes in view of the risk to the child of future serious complication and the effectiveness of therapy.

If school children are being tested, the grades tested will depend somewhat on the number of new infections expected per year. In a low area it may be sufficient to test beginning students in kindergarten or the first grade, children about to leave elementary school and the last year in high school. In a high rate area it may be worthwhile to test all grades every year. Such group tuberculin testing programs must be carefully planned so the essential followup of contacts will not be neglected and to provide for a critical evaluation at the end.

Tuberculin testing of children cannot take the place of the established public health program for tuberculosis control. Isolation and treatment of infectious patients, supervision of inactive cases, examination of contacts of active cases, x-ray screening of high rate groups, and programs to improve general public health are basic to any organized attack on the disease. However, routine tuberculin testing by all physicians coupled with well planned group testing of school children and others in a community can provide additional information useful for a more direct attack on the disease with the present effective therapeutic tools.

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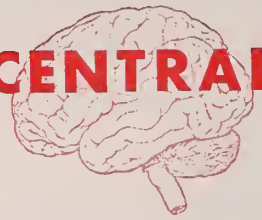
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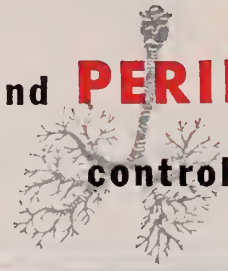
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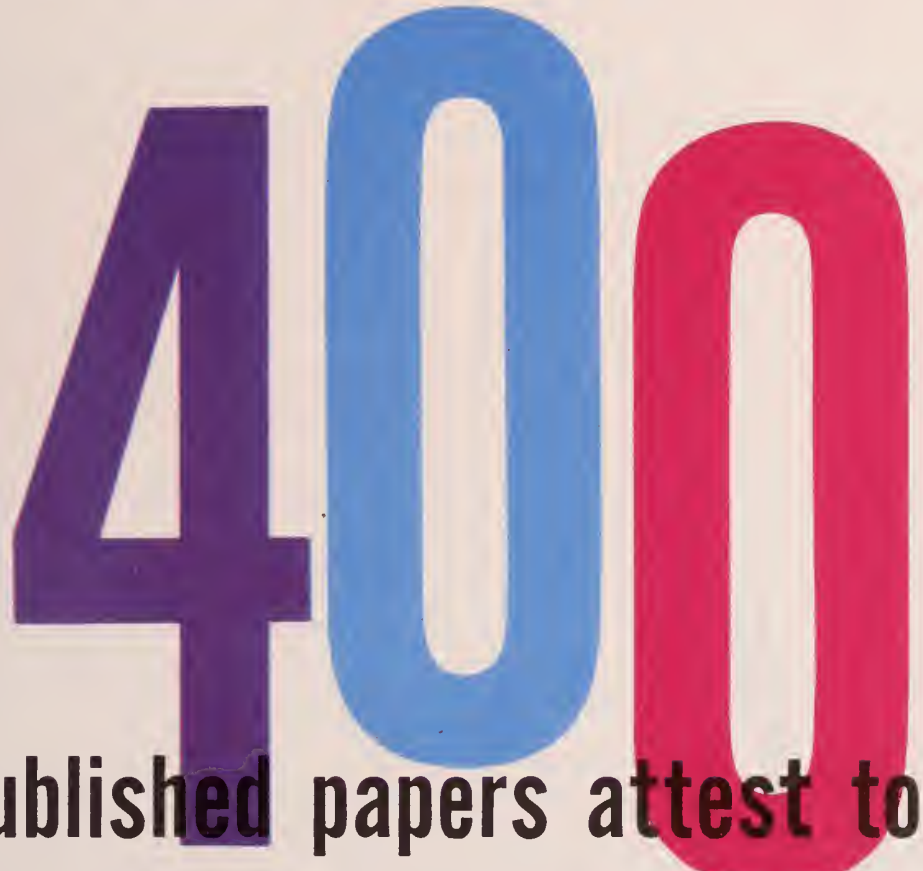
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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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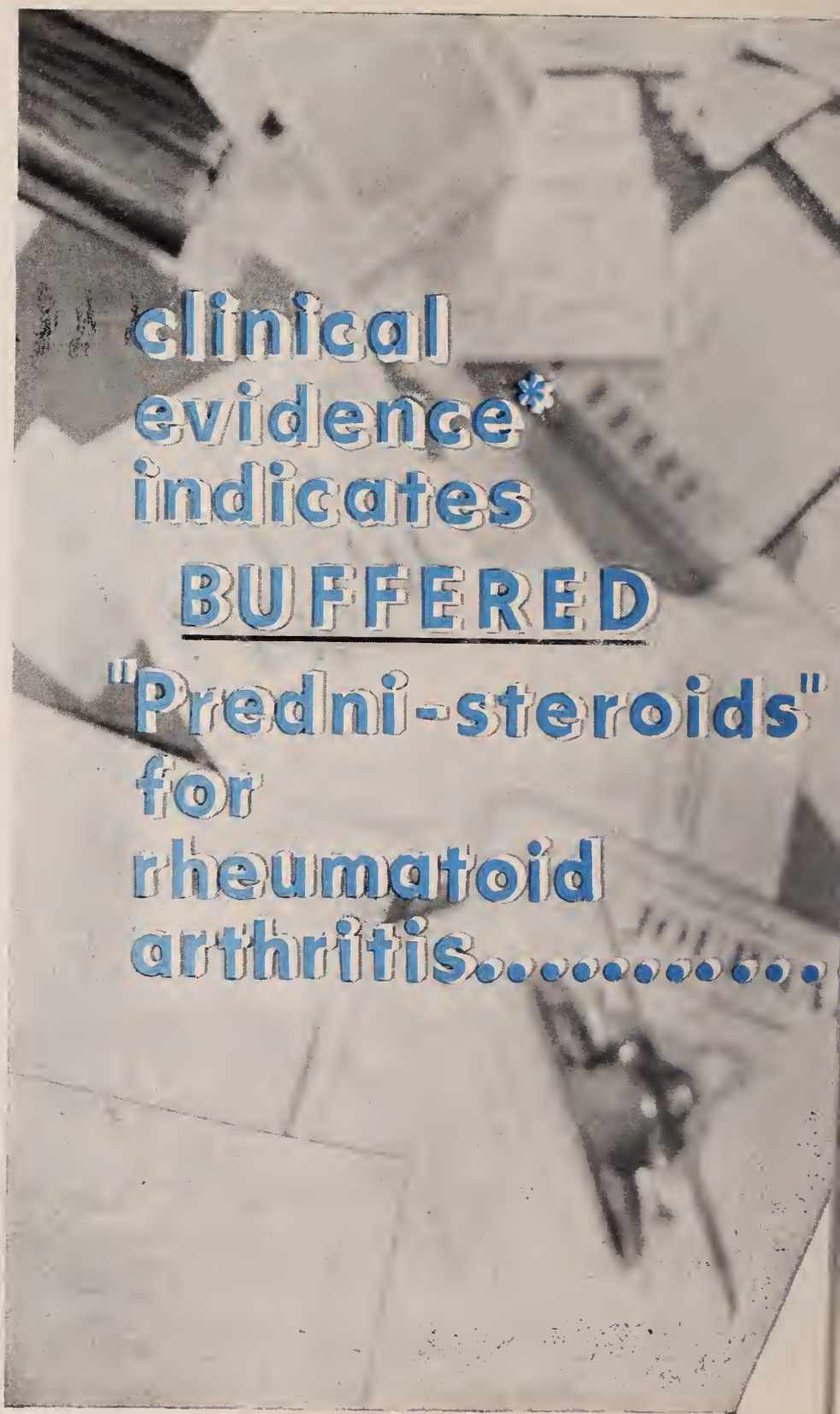
CHILDREN—5 to 7 mg. per Kg. (2.2 to 3.1 mg. per lb.) per 24 hours.

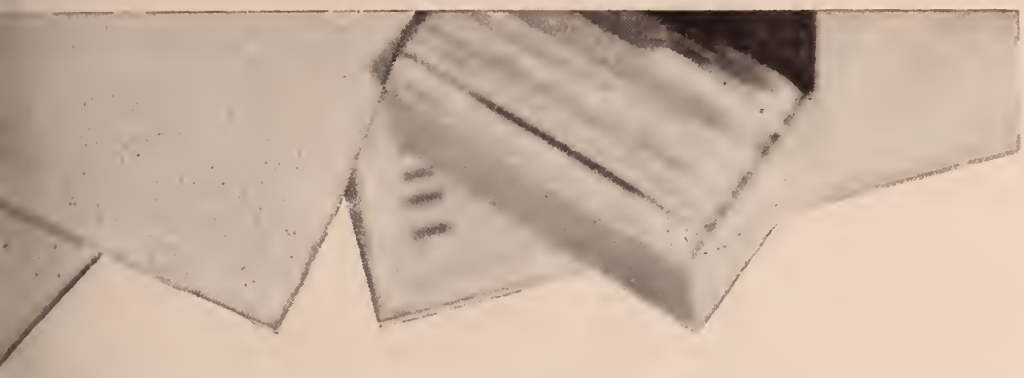
SUPPLIED: Tablets, 50 and 100 mg. Oral Suspension (25 mg. per 5 cc. tsp.).

*Stewart, B. J., and Rowe, H. J.: J. Am. M. Ass. 160:1221, 1956.

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tly with prednisone and predni-
ne, we feel that these measures
uld be employed prophylacti-
y to offset any gastrointestinal
effects."—Dordick, J. R. *et al.*:
. State J. Med. 57:2049 (June
1957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high in-
dence of this serious gastro-
side effect in patients re-
prednisone or prednisolo-
suggests the advisability of
routine co-administration of an
aluminum hydroxide
Bollet, A. J. and Bruhn, J.
J. A. M. A. 158:459 (June
1955.

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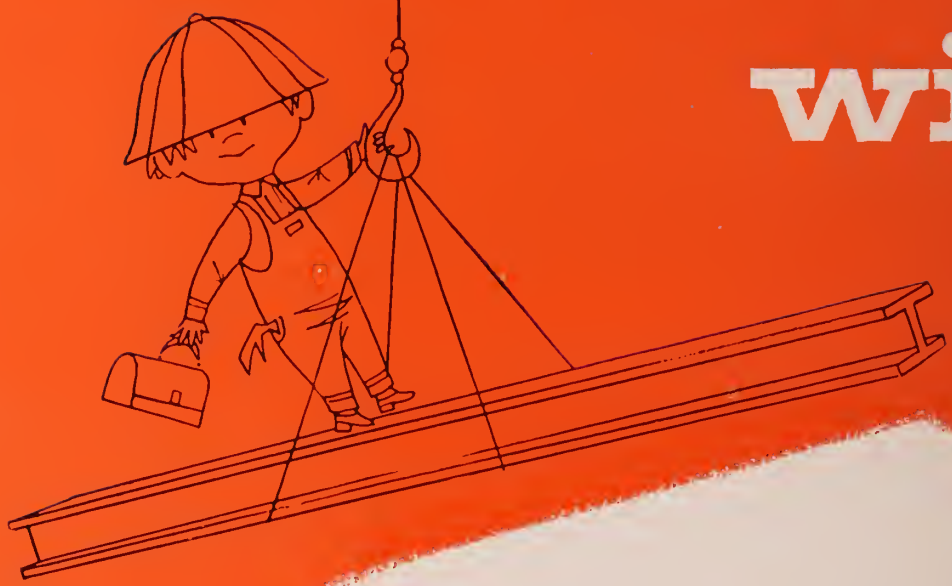
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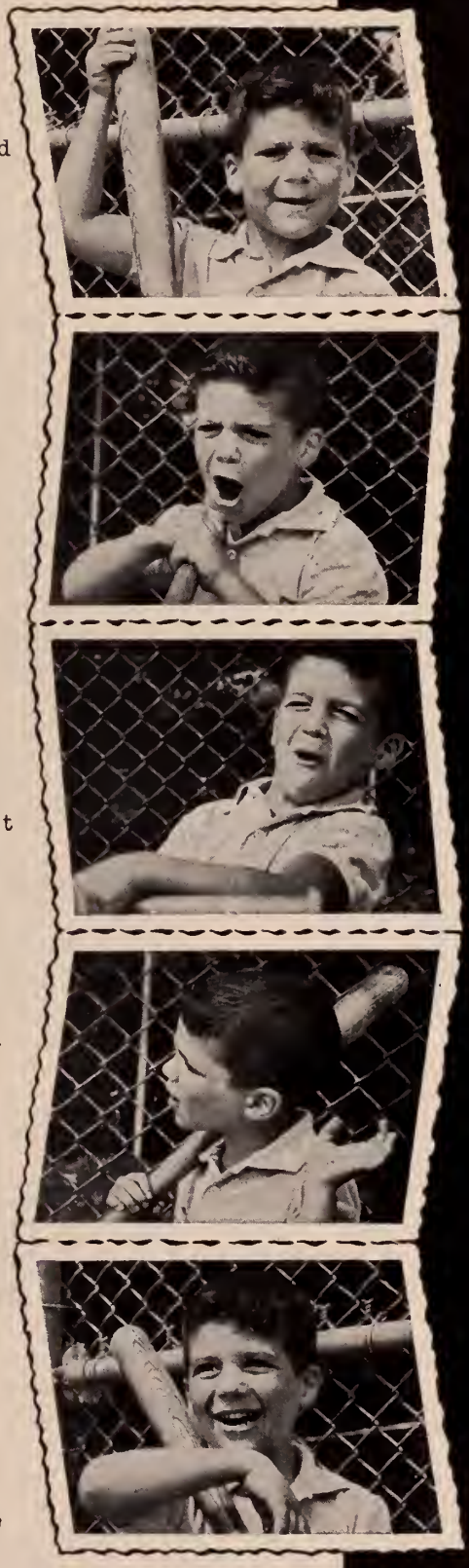
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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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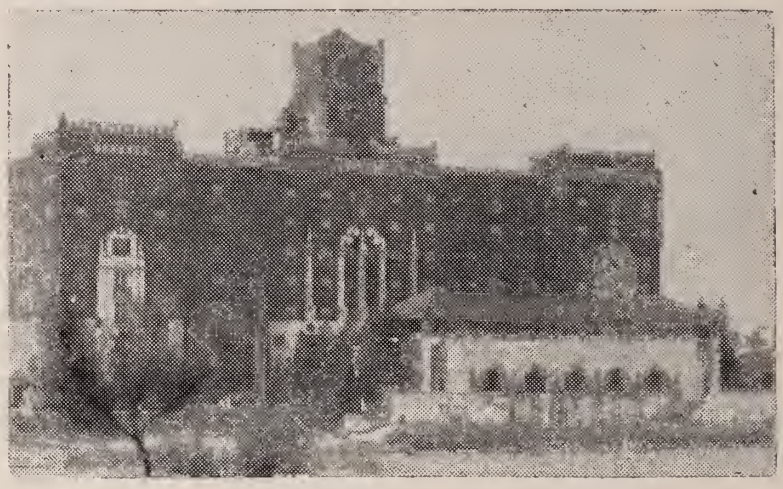
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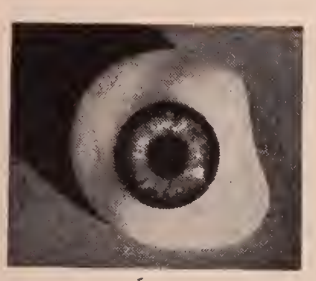
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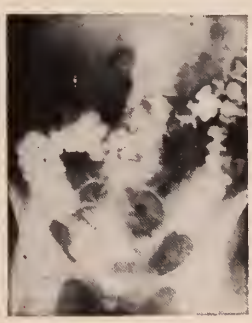
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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: J.A.M.A. 157:1194, 1955.
3. Zimmerman, F. T.: *Arch. Neurol. & Psychiat.* 76:65, 1956.



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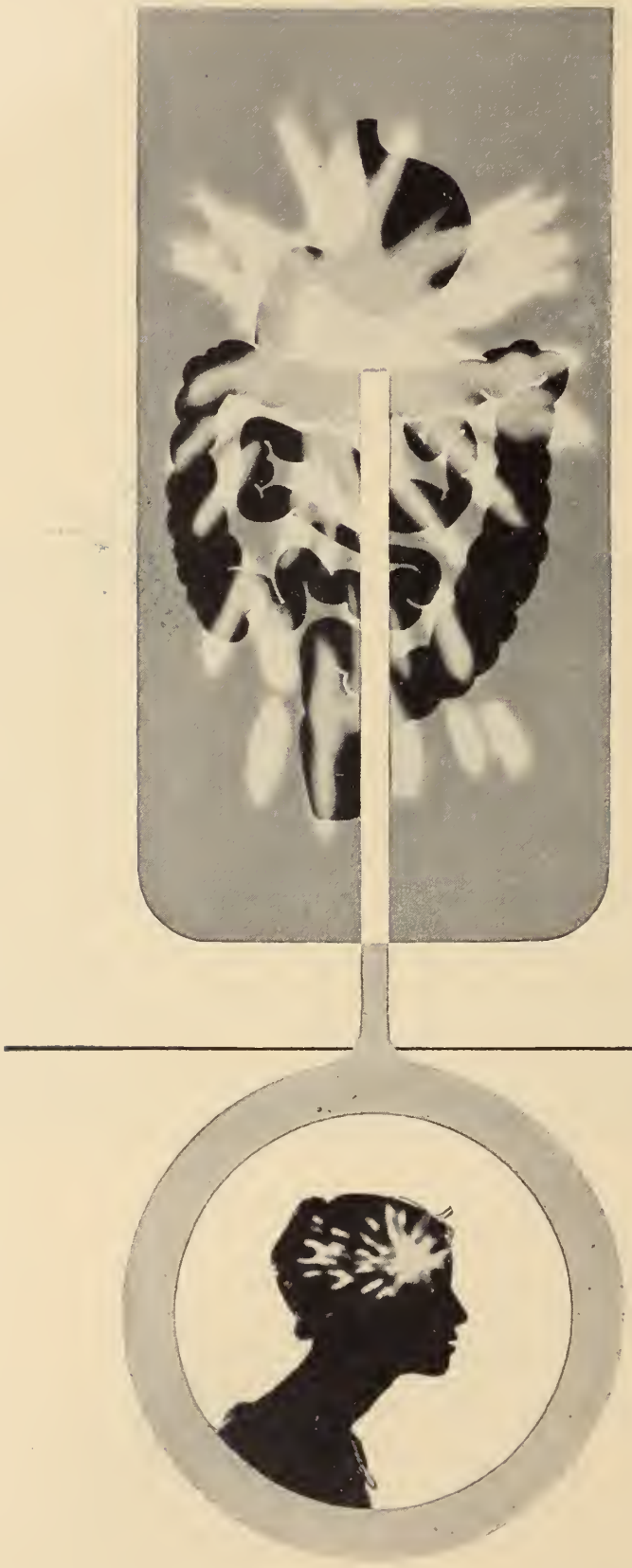
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OF

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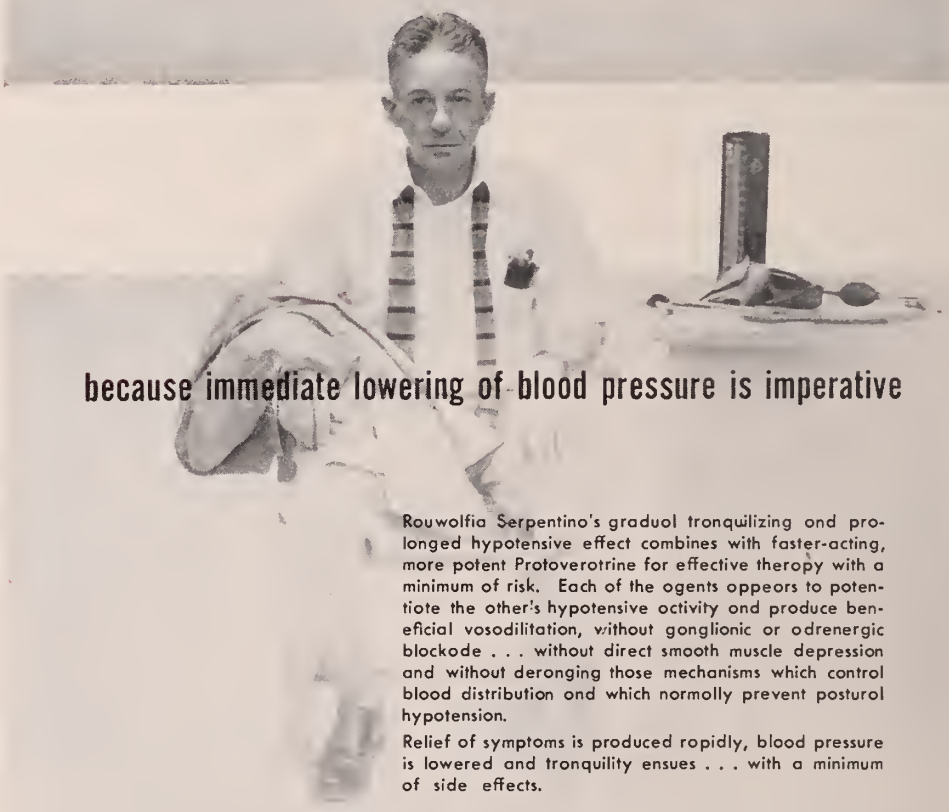


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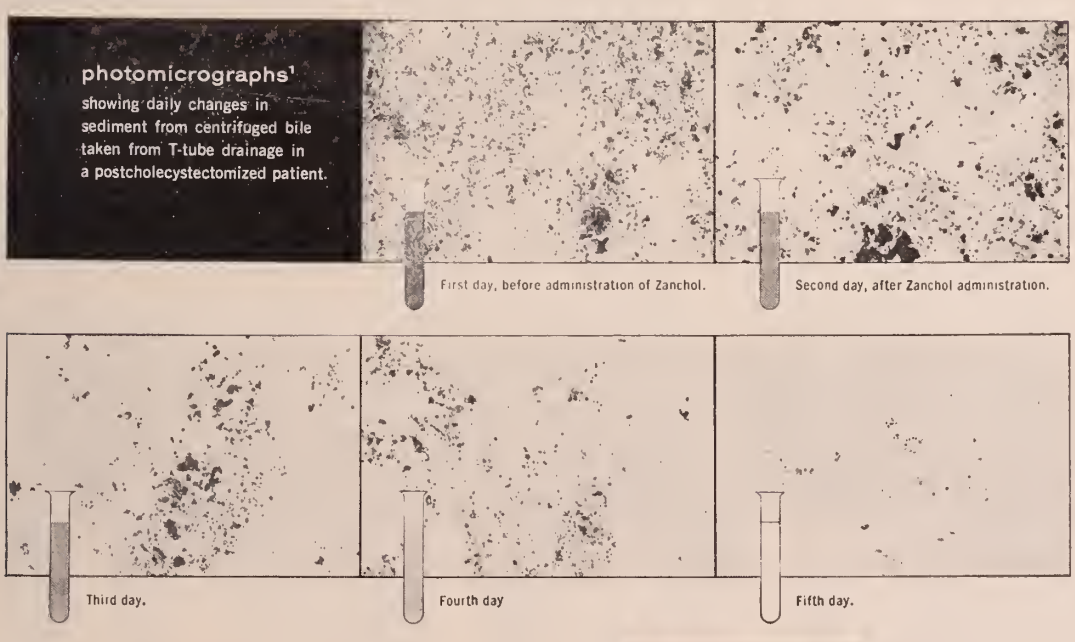
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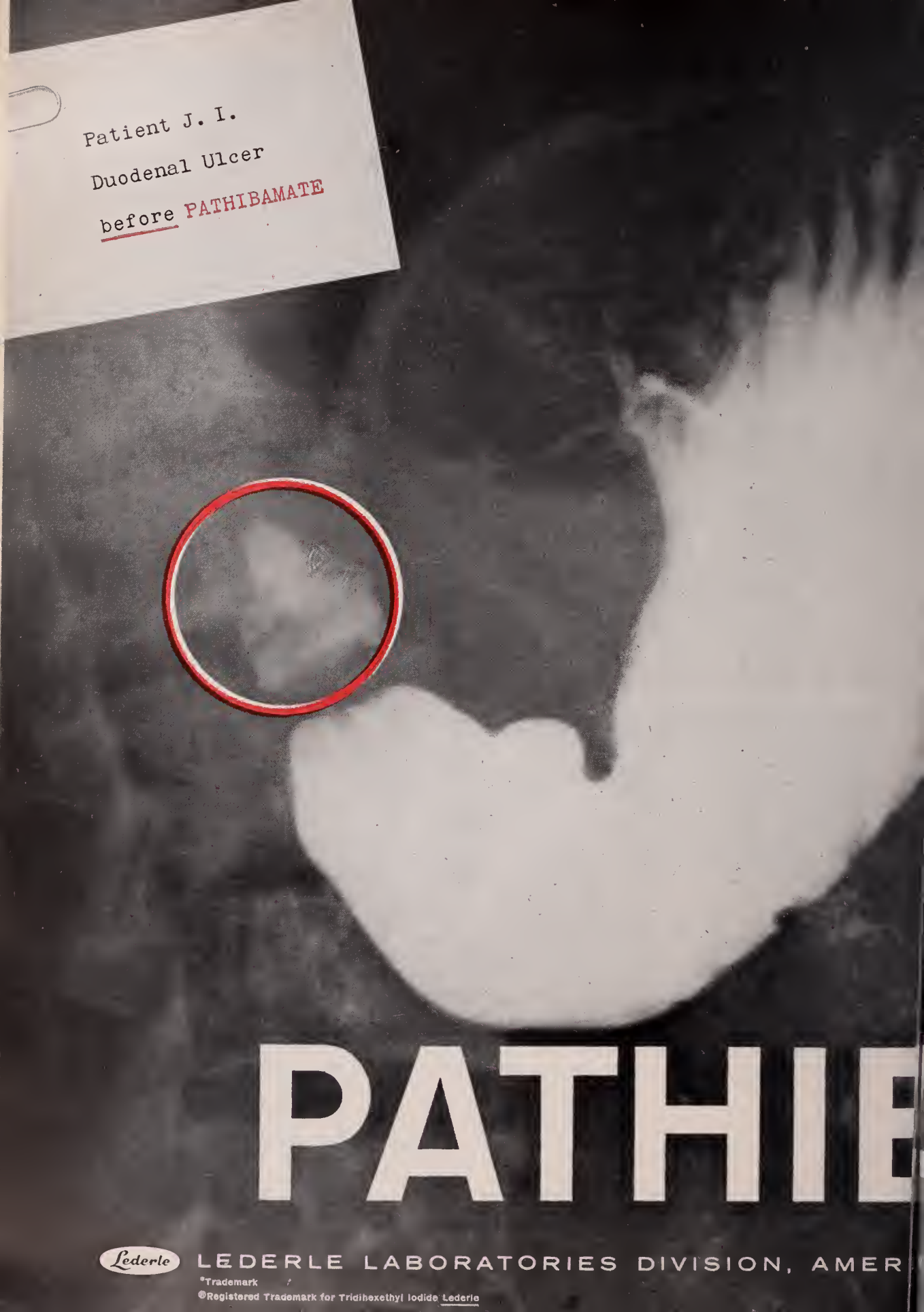
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1. McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. *103*:163 (Aug.) 1956.

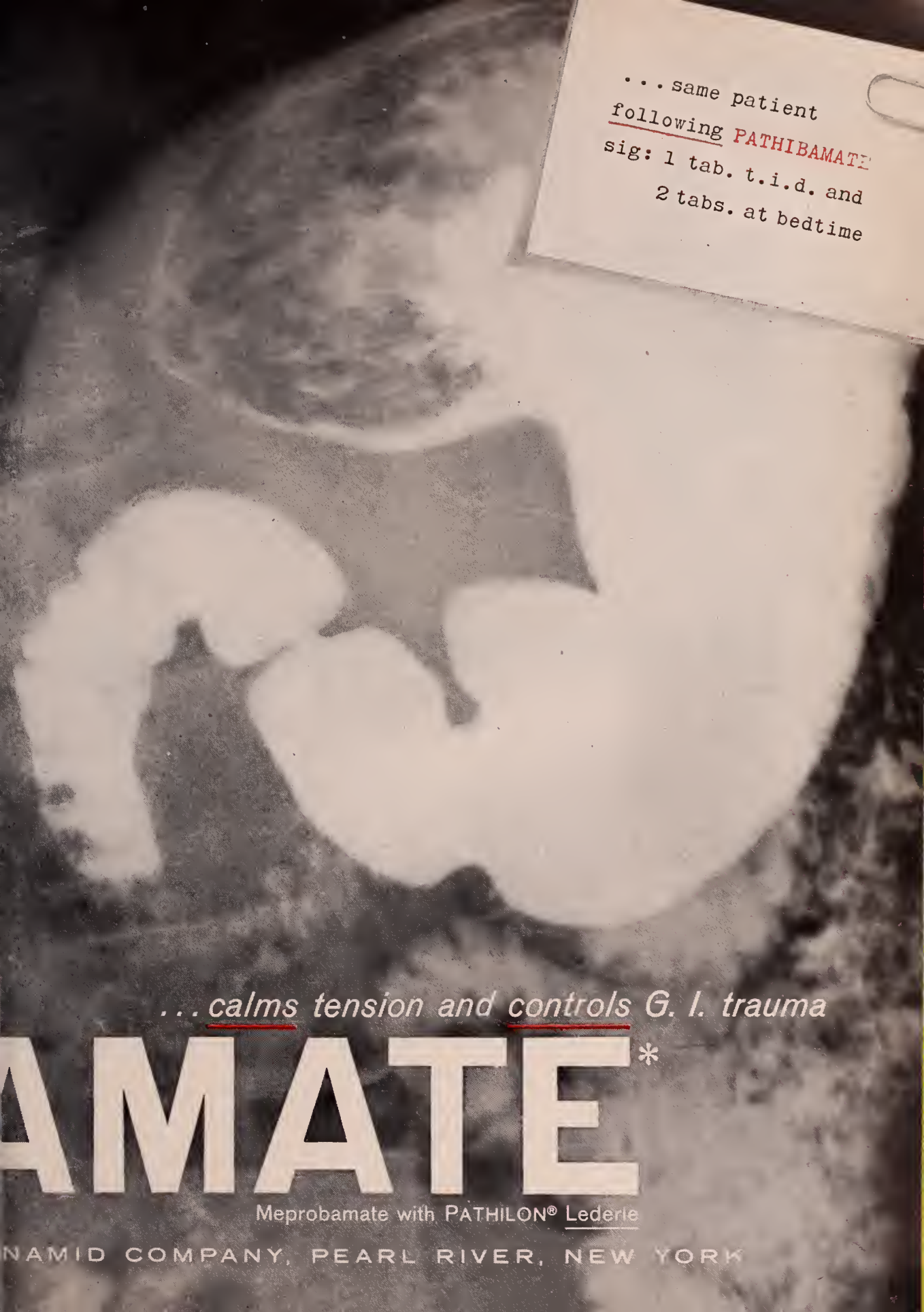
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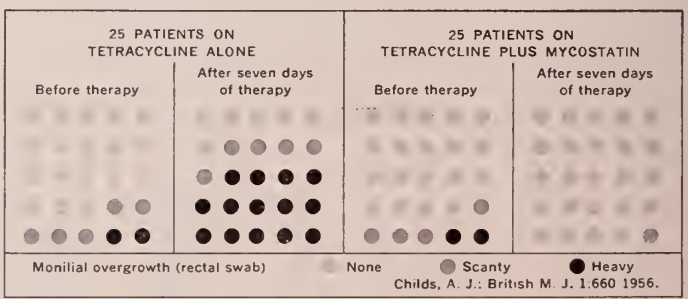
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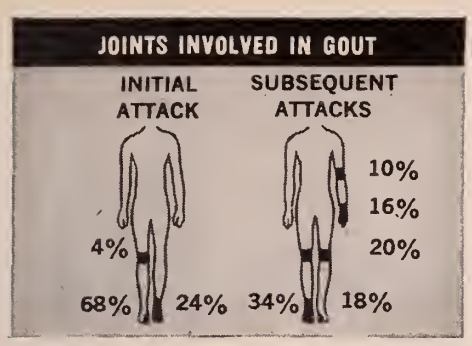
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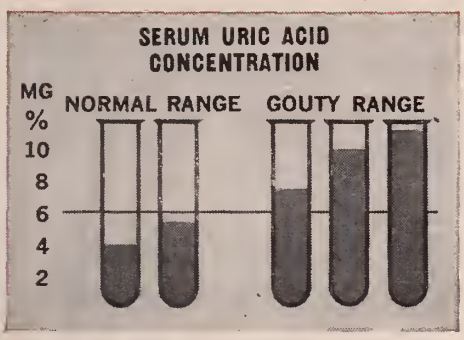
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1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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May we call your attention to an important development in the clinical use of Marsilid -- the new psychic energizer which is of impressive value in the treatment of depression?

Recent studies have confirmed the fact that Marsilid is a highly potent drug. Therefore it is essential to use the correct dosage if good results are to be obtained with minimum likelihood of side effects. There can be no doubt that excessive doses may cause potentially serious side reactions.

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In rare cases, Marsilid may cause jaundice, particularly when it is given in excessive doses. Similarly, hypotension and other side effects may occur in patients on excessive dosage but they are very rarely encountered on a daily dose of 50 mg or less. The precautions listed in the enclosed literature should, of course, be kept in mind.

Incidentally, an entirely different dosage schedule is required for institutionalized mental patients. When regressive or depressive psychoses have lasted for a period of years, 150 mg Marsilid may be needed, given in single daily doses. But such high doses should not be used in ambulatory patients with mild depression.

As is true of cortisone, digitalis and other potent drugs, Marsilid (iproniazid) has to be used with care and attention must be paid to accurate dosage adjustment. But we believe that by observing the precautions mentioned in this letter and by following the directions in the enclosed literature, you will be able to obtain gratifying results with Marsilid -- results unexcelled by any other method of treating depression.

Sincerely,

S. Evert Svenson, M. D.
Director of Medical Information

SES:dz

P.S. This letter with the latest information on Marsilid was mailed to most practising physicians. In case you overlooked it, you may be interested in this copy.

Roche Laboratories
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See other side
for important announcement
on Marsilid dosage.

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Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

Available on prescription only.

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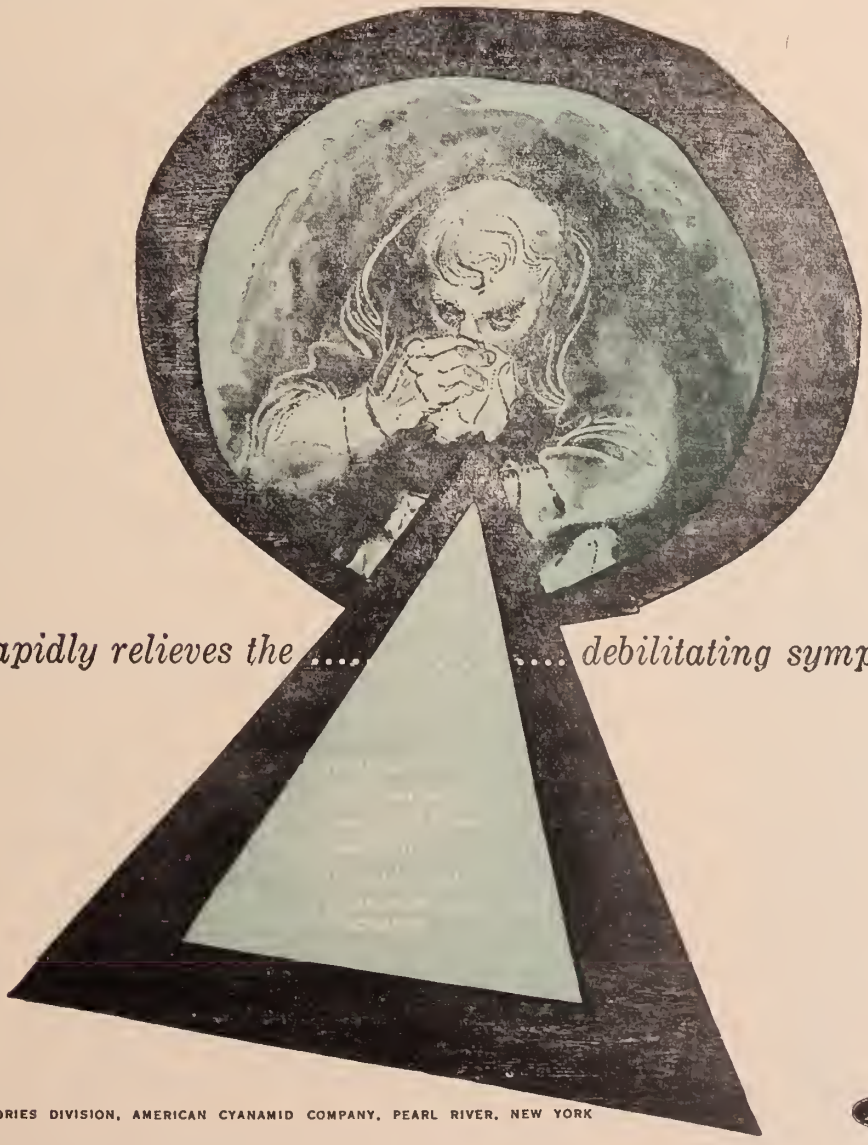
ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
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Bottles of 24 and 100.

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SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

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BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
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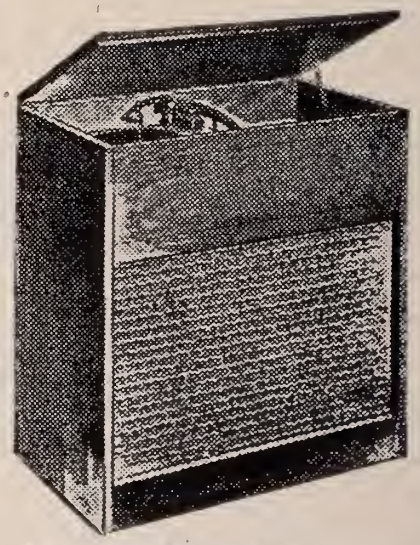
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

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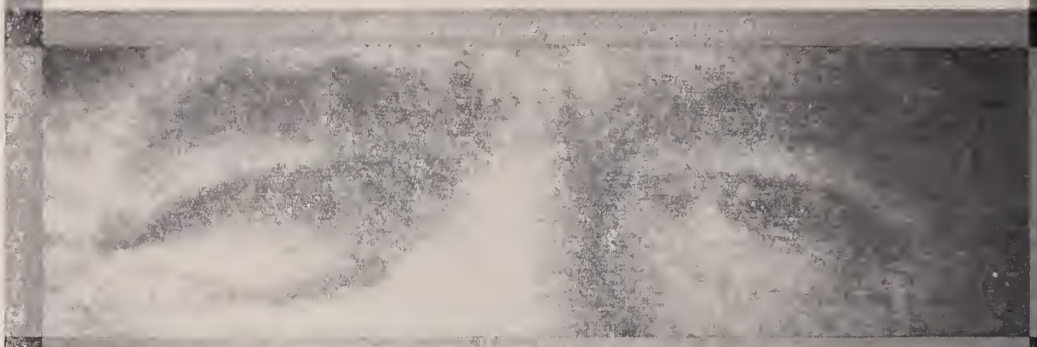
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(1) Don't argue—let patient "talk out" his troubles. (2) Don't counsel—help him solve his own problems. (3) Don't be hostile—allow patient to express hostility without reciprocating. (4) Don't be unsure—stress significance of normal or abnormal physical findings in relation to symptoms. (5) Don't be too reassuring—overoptimism may suggest you take the symptoms too lightly. (6) Don't approve or censure. (7) Don't be too credulous—patients' words may conceal hidden meanings.

Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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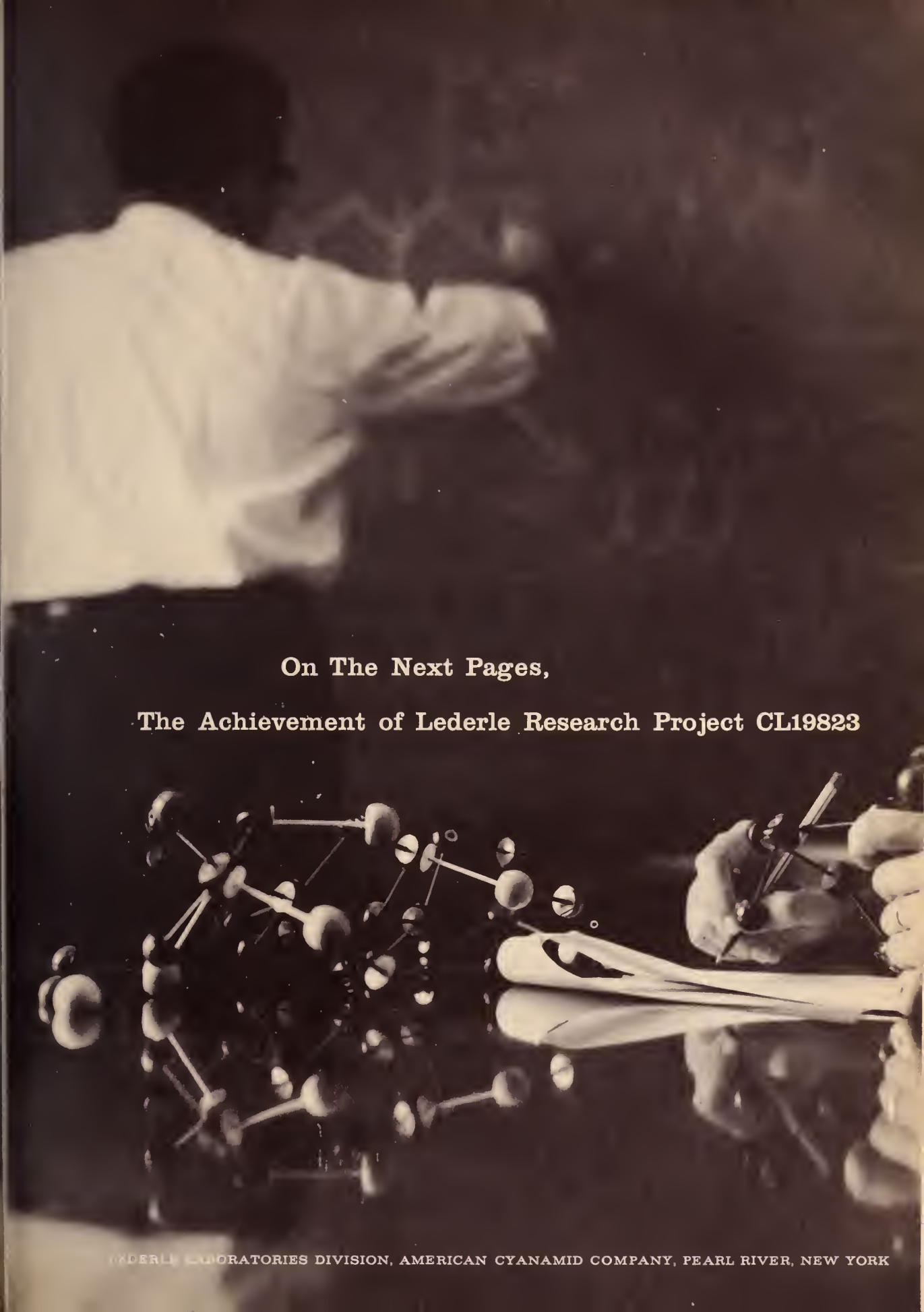
"Anxiety and nervous tension states appeared to be most benefited....The patients experienced and expressed a feeling of greater inward security, serenity....Mental depression, one of the undesirable side actions in many other sedatives, did not develop in any of the patients...."*

*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: A Clinical Evaluation of Ectylurea (NOSTYN®), in press.

dosage: *Children*—150 mg. (½ tablet) three or four times daily. *Adults*—150-300 mg. (½ to 1 tablet) three or four times daily.

supplied: 300 mg. scored tablets; bottles of 48 and 500.

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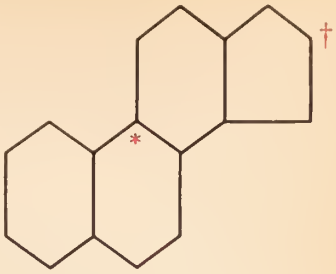
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Triamcinolone LEDERLE

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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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Lederle

The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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Lederle

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957. 2. Hartung, E. F.: Paper presented at Florida Academy of General Practice, St. Petersburg, Florida, Nov. 2, 1957.

Lederle

The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Schwartz, E.: Personal Communication. 4. Spies, T. D.: Personal Communication. 5. Barach, A. L.: Personal Communication. 6. Segal, M. S.: Personal Communication.

Lederle

The Promise of Aristocort

in Nephrotic Syndrome

Fourteen patients with the nephrotic syndrome have been treated with ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

Eleven patients with pulmonary emphysema and/or fibrosis were treated with ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

◊ *Forty-four children and adults have been given* ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

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The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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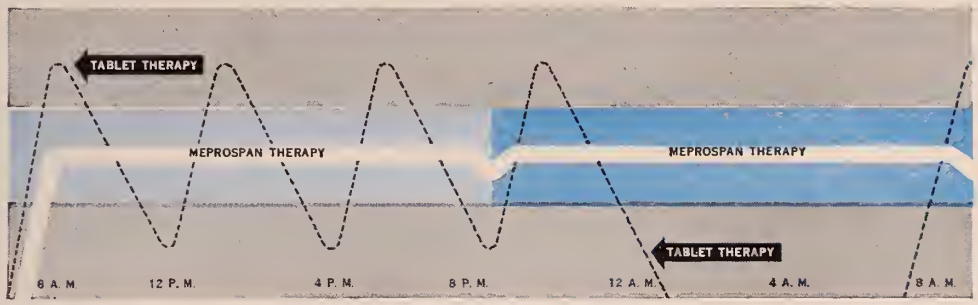
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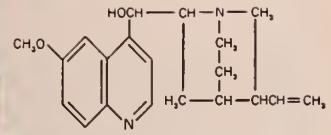
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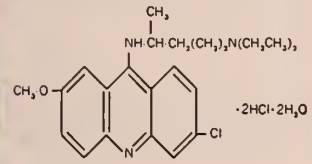
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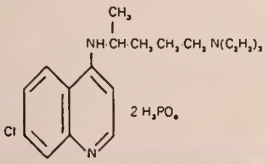
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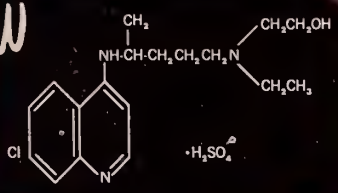


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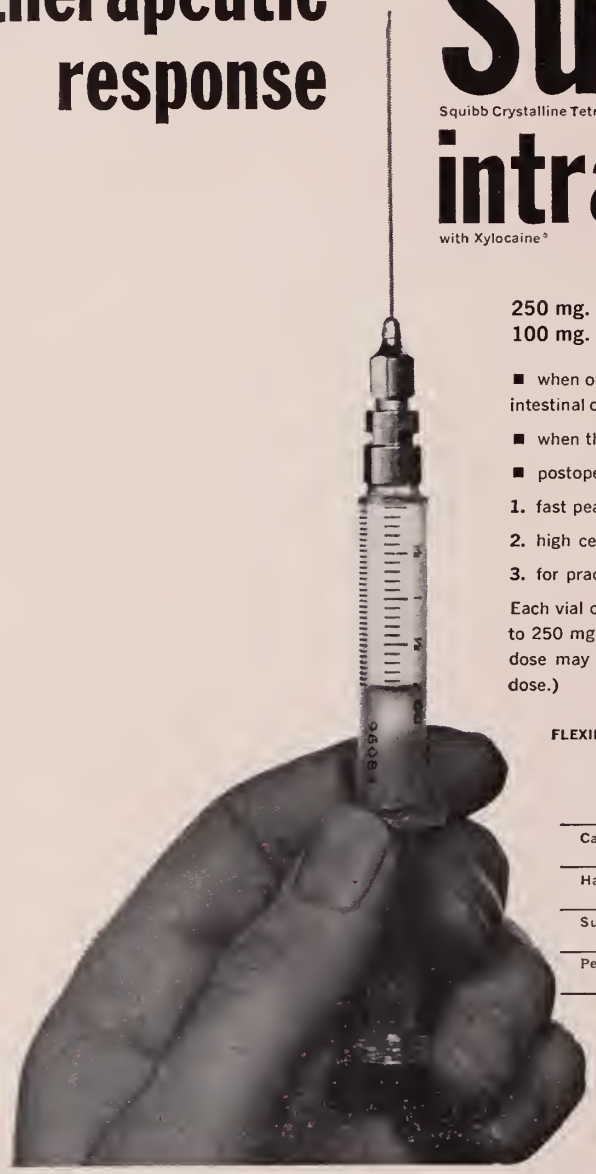
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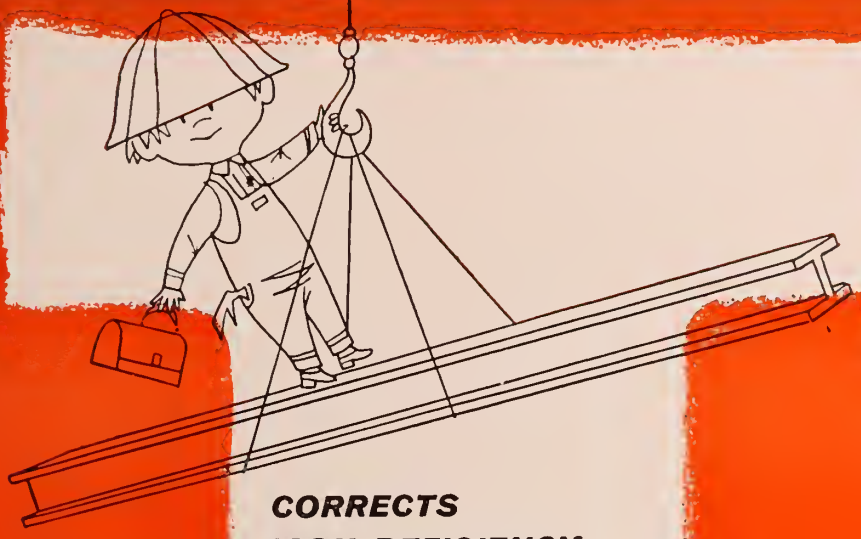
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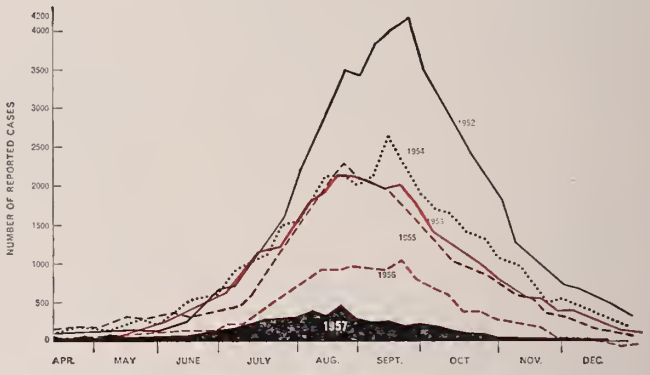
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1. *J. A. M. A.*, 165:21 (*November 23*), *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*



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Editorials

The Forty Days of Quarantine

Add to the list of fading medical modalities, the forty days of quarantine. That's what the word means: 40 days. Once exposed to pestilence, men and merchandise had to be isolated for 40 days—hence the word *quarantine*. The idea was that some mystic miasma caused the disease, and in 40 days that miasma would somehow be gone with the wind. When a ship came in from other (and therefore suspected) parts it anchored midstream and the merchandise and merchant sailors were checked for disease. If none was found, a "bill of health" was given. Otherwise, the men and the freight remained in an off-shore wooden prison until the 40 days had ended. And when they said isolation in those days, they meant it. Harsh penalties—including hanging—were applied to those who broke quarantine. For the fear of pestilence rode high in the land.

It took some arguing to get nations to honor the "bill of health" of another country. Finally at the International Sanitary Convention of 1851 (a mere century ago), it was agreed to accept a certified "clean bill of health" for a ship without added quarantine. For another 30 years, the theory of a dissipated miasma still dominated public health thinking. Then, towards the end of the century the new science of bacteriology began to pull up the shade. Koch's finding of the cholera germ in 1884, for example, opened the door to rational cholera prevention. In 1894 the great plague itself was shown to be due to a bacillus; and the role of rats and fleas and lice in the distribution of the plague was demonstrated. In 1907 came the International Office of Public Hygiene and finally, in 1912, the rationalization of quarantine.

The story might have ended there, since public health knowledge in the 1912-1930 period was advanced enough to remove the need for irrational methods of disease control. But time gave it a new twist. The aeroplane. Now a tropical disease could be carried to a temperate climate in a single night. So new regulations—not a "quarantine" this time—had to

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be developed. In 1933 came the first International Sanitary Convention for Aviation. And in 1946, the World Health Organization took over the responsibility for framing regulations to prevent disease from leaping the oceans.

So compulsion is now reduced to the three vaccines: small pox, yellow fever and cholera. Hospitals are available to isolate infected persons. Provisions exist for putting contacts under surveillance, without harsh restriction of liberty. Insecticides have removed much of the fear. Rising living standards have reduced much of the exposure. And tomorrow's medical students may scarcely know the meaning of that once so-important word: quarantine.

Medical Education Week

Each member of our Society has an opportunity this month to honor and aid his medical school by helping bring the third annual observance of Medical Education Week to the attention of his patients.

During the week of April 20, the medical profession will join forces with the Woman's Auxiliary and the medical schools throughout the country in presenting programs emphasizing the progress, problems, and challenges of medical education. The world leadership of American medical schools, their research triumphs, and community services are little known by the public. Medical Education Week is designed to create greater public appreciation and support for their continuing achievements. And not least of all, is the immense cost of medical education which already is a $200 million annual undertaking.

The six specific aims of Medical Education Week are to:

(1) Portray the key role that medical education plays in the maintenance of the nation's health and security, and make the public aware that the nation's 83 medical schools are the foundation of our entire health and medical structure;

(2) Explain how the medical schools are meeting the demand for more physicians;

(3) Call attention to the steady progress in the medical sciences, showing what this means in terms of longer life and better health;

(4) Point out the wide range of activities —teaching, research, service and leadership— carried on by the modern medical school in addition to its job of training new doctors;

(5) Make clear the extent and nature of the new challenges to the profession and

(6) Point out some of the steps being taken constantly to push back the horizons of the medical sciences and to realize the full potential of the nation's health resources.

These objectives are emphasized in a coast-to-coast promotional effort developed by the national sponsors of Medical Education Week.

President Eisenhower, in his personal endorsement, has already invited the American people to set aside this week to consider the work of our medical schools, but its ultimate success will depend most directly on how well and how actively we initiate and conduct this annual community salute to our medical schools—Medical Education Week, the week of April 20.

Silent Surgery

"He that open wide his lips," says the Bible,[1] "shall have destruction." And now comes a professor of surgery and his resident to demonstrate that, in the operating room, this is indeed so. For Byrne and Okeke[2] have shown that when you talk, even though surgically masked, you spread more germs than when you remain silent—even if unmasked. Somehow, *staphylococcus aureus* seems to be carried on the wings of words, expelled out of the explosions of a man who shoots off his mouth. A single mask, even a double mask, offers scant screening against this golden germ. But when the operators remain mute — though unmasked—few staphylococci escaped. Thus by an odd irony, the golden silence suppresses the golden coccus.

During the past year there has been increasing uneasiness about operating room infections. The bacteria have, perhaps, learned to brace themselves against chemotherapy and antibiotics. We have grown a bit over-confident. Well, here is a way of reducing the bacterial spray at the source. Let the operating room echo with the eloquent silence of a Trappist monastery. Let surgeons develop hand signals to call for scalpel, suture and scissors. This will be, as Thoreau has put it, "a silence audible to all men." Silence then will be golden. And, as Fuller reminds us, silence seldom hurts.

Is Medicine in the "Insurance Business"?

More than 70 medical society-sponsored Blue Shield Plans are serving one-fourth of the people of the United States, and underwriting 40 per cent of all the basic surgical insurance and 50 per cent of all the basic medical (non-surgical) insurance now in force. The rest is underwritten by more than 800 private insurance companies and independent local plans.

Is medicine—by its sponsorship and control of Blue Shield—in the "insurance business?" Well, the medical profession organized these Plans at a time when the insurance industry said it couldn't be done. And they were right. Medical care prepayment couldn't be organized and offered by an insurance company. It had to be done by medicine itself.

Blue Shield succeeded because America's doctors were behind it. They accepted less than normal schedules for their services; they agreed to accept (and in many areas they have actually accepted) pro-rated portions of those fees when the local Plan has been unable to pay the full schedule. Medicine's leaders have accepted the responsibility for guiding and directing their local Blue Shield Plans—a job that accounts for an incalculable number of unremunerated hours on the part of hundreds of the country's busiest physicians.

Have we accepted these duties and responsibilities in order to put medicine "in the insurance business?" No, we are in the business of providing medical care—nothing else. The profession has always been concerned with the means by which patients pay for medical care and provide for future medical needs. We would prefer to have a voice in the basic economy of medical practice.

Medicine is *not* in the insurance business. But, through Blue Shield, the profession *is* in the business of helping patients pay for their doctors' services. And in the final analysis, the patient alone profits through participation in Blue Shield.

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Dayton T. Kieswetter, M.D.

East Orange

Non-Icteric Infectious Hepatitis

Fatigue, depression and vague gastro-intestinal complaints suggest psychoneurosis. However, this may also be the syndrome of non-icteric hepatitis. The physician is urged to be alert to this possibility. Liver function tests constitute the simplest and swiftest indicator.

Infectious hepatitis is, today, a disease familiar to most physicians. When accompanied by jaundice, it is usually quickly recognized. In a non-icteric form, this disease is much more frequent than most physicians realize since, in the absence of jaundice, few of us think of it.

Rokitansky first described the disease in 1842. By 1865, Virchow had reported mild forms of it. Not until 1939 was it demonstrated (by Reholm and Iverson) that the primary pathology was in the liver parenchyma. The huge epidemics of World War II added tremendously to the knowledge of infectious hepatitis. In the United States Army alone there were 170,000 cases,[1] stimulating a tremendous amount of research and investigation. From these and subsequent studies a fairly clear picture of the disease has been determined.

The viral etiology of infectious hepatitis is well established. Henle's studies[12] showed the viral cause by isolation and propagation of the viral agent in the amniotic fluid of the embryonated egg. Eichenwald[7] differentiated the virus of infectious hepatitis from the virus of homologous serum jaundice. The virus was identified in both blood and stools. Capps *et al.*[13] transmitted the disease to two human volunteers by means of stool extracts.[14] From these and other studies they felt that the disease is spread by the fecal-oral route. The virus is hardy, surviving concentrations of chlorine normally used to purify drinking water.[1] It has been reported to survive boiling for ten minutes, making sterilizing by boiling seem inadequate.

The incubation period has been estimated by Stokes[11] to be about twenty to thirty days, but Eichenwald[7] feels it ranges from ten to fifty days. He reports that the typical case has an abrupt onset and evidence of immunity when the infection is apparently over. Skin tests with a moderately infective hepatitis strain have indicated that 35 per cent of adults are immune and therefore presumably have had the disease at some earlier time.

The disease is apparently world-wide in its distribution, and tends to occur more in fall and winter, with smallest incidence in the summer.[5]

The pathology of infectious hepatitis is largely limited to liver cells with the extent of injury generally in proportion to the severity of the disease. In the non-icteric group the changes are generally mild with inflammatory exudates limited largely to the portal areas.[1] Some observers believe that these mild changes can become chronic with the development of cirrhosis of the liver.[7] Others[2] deny this.

Capps *et al.*[14] found a large number of cases in infants under three years of age. Three-quarters of these infants had "loose stools"; 72 per cent had fever; 75 per cent had definitely enlarged livers; and 50 per cent showed a failure to gain weight. There were no other findings common to the majority. In a group of young soldiers (age 17 to 22) reported by Chancey and Zatz[15] all of whom had upper respiratory infection plus infectious hepatitis, 95 per cent had epigastric or liver area pain, 90 per cent had fatigue or malaise, and 72 per cent had anorexia. All had tender livers and 52 per cent had lymphadenopathy and/or splenomegaly.

Denber and Leibowitz[2] in a report on 30 cases of anicteric hepatitis, found that 86 per cent complained of fatigue, 73 per cent anorexia; 72 per cent reported distaste for smoking. Headache, nausea and abdominal pain were common. In this series 79 per cent had tender liver with 56 per cent showing hepatomegaly. They noted enlargement of posterior cervical lymph nodes in 50 per cent. Zimmerman and Thomas[3] and Finks and Blumberg[4] also noted a high frequency of anorexia, epigastric fullness and pain and headache as the only symptoms present in the majority.

With such non-specific symptoms and signs, reliance has had to be placed on laboratory tests to make the diagnosis in most cases. Capps *et al.*[14] found the thymol turbidity elevated in all cases, and the cephalin flocculation high in 78 per cent. They also found elevation of cholinesterase in 91 per cent, urine urobilinogen in 63 per cent and high alkaline phosphatase in 44 per cent. At three months, 66 per cent still had positive tests; in six months 19 per cent. Denber and Leibowitz[2] also found the thymol turbidity elevated in 100 per cent. In their series 86 per cent showed elevated cephalin flocculation; 26 per cent had over 10,000 leucocytes per cubic millimeter. Fever was noted in 46 per cent. The serum bilirubin was under 1.2 in 75 per cent and under 2.0 in the remainder.

Harrison[1] notes that the cephalin flocculation tests and the thymol turbidity are generally elevated but finds that bromsulfalein assay is the best method of following the patient in the convalescent period. He notes that liver biopsy may sometimes be necessary to answer problems of diagnosis and recovery.

Differential diagnosis is particularly difficult in this subicteric hepatitis unless laboratory tests are available. Psychoneurosis or "gastrointestinal grippe" are the commonest erroneous diagnoses given these cases. Of the more specific diseases to be considered, mononucleosis and brucellosis are the most likely. Consideration also has to be given to chemical toxicity, malaria, secondary syphilitic hepatitis leptospirosis and pneumonia.[2]

Treatment is that of infectious hepatitis whether jaundice is present or not. The response is generally more prompt in the subicteric type[6] since it is a mild form to start with. Rest is the first principle of therapy for both the severe forms and the subicteric groups.[10] Specific therapy is lacking. Antibiotics are of no help in uncomplicated cases.[7]

A diet relatively high in calories and carbohydrate, with normal proteins and normal or moderately low fat and no alcohol is recommended for the mild case, as are vitamin supplements. Lipotrophic substances such as methionine are of questionable value. Parenteral feedings and use of ACTH and corticoids[8] are rarely necessary because of the mildness of the condition. Antihistaminics sometimes are helpful in the control of nausea. Barbiturates as in any disease involving the liver, are often excessively effective or unpredictable.[10]

The disease is usually benign. A chronic course or a change to an acute fatal hepatitis is rare. The patient can be safely started on limited activity when all symptoms are gone. He should not be allowed to resume full activity until the tests are stabilized, though they need not have fallen to the normal zone.[7]

It is important to make a specific diagnosis of this disease for three reasons. *First*, to reassure the patient that the disease, while protracted, is one from which complete cure can be expected. Only one per cent of cases even

with jaundice fail to return to normal.[1] *Second*, so that the patient can be placed on the regime which will speed recovery. *Third*, so that close contacts can be protected to some degree by gamma globulin. This protection lasts about six weeks.[9]

During the last two years, I have seen six cases of infectious hepatitis without jaundice. These are presented briefly below.

CASE ONE

A 32-year old housewife was first seen complaining of fullness in the epigastrium, anorexia, and nonspecific malaise. She had considerable eructation and some aggravation of symptoms following eating. Outstanding in her symptomatology was depression and tearfulness. She had variable right upper quadrant pain and tenderness. Physical examination was normal in all respects except for the liver which was tender with a sharp edge palpable 3 centimeters below the costal margin. Blood count, sedimentation rate, urinalysis, gastro-intestinal x-rays, stool examination, and electrocardiogram were all normal. X-ray revealed a single large gallstone. Liver studies showed the cephalin flocculation to be 3 plus in 24 hours; the thymol turbidity 9.2, and the serum bilirubin 1.4; heterophile antibody test was negative. On a routine of rest, high protein, high carbohydrate, low fat diet and vitamins, she slowly recovered with many emotional ups and downs during the next five months. Thymol turbidity rose to 10.4 and then fell to 3.0 by the fifth month. The cephalin flocculation continued at 3 plus for three months and then dropped to 1 plus. The serum bilirubin was essentially normal throughout her illness. The liver slowly decreased in size and tenderness, becoming normal about the end of the second month. The patient has been normal physically, emotionally and from a laboratory standpoint, for six months.

CASE TWO

A 25-year old school teacher was first seen because of dizziness, drowsiness and emotional instability. She had felt weak and somewhat nauseated with a fullness in the upper abdomen. Physical examination was normal in all respects except for a tender liver and a fever of 99.6. Blood count, sedimentation rate, serology, routine urine, were all normal. Thymol turbidity was 10.5; cephalin flocculation 4 plus in 24 hours. Bromsulfalein was 5.5 per cent in 45 minutes; serum bilirubin was 1.0. The patient had some epileptiform seizures. This was confirmed by electro-encephalography. The convulsions responded to phenobarbital. The symptoms of fatigue, depression, mild nausea, and upper abdomen fullness continued, however. On a routine of rest, high protein, high carbohydrate, low fat diet and vitamins, she gradually recovered over the next two months. During this time the thymol turbidity rose briefly to 12.8, but by the end of one month was down to 9.0 with a two-plus cephalin flocculation. By the end of two and one-half months, the thymol was 5.9, and the cephalin flocculation was two-plus, and after four months the tests were 3.7 and 1-plus respectively. Apparently the seizures were brought on by the hepatitis, since, without medication, she has been free of any smptoms for many months.

CASE THREE

A 32-year old housewife complained of malaise, depression, pains across her upper abdomen, and headache of three weeks' duration. Physical examination was entirely negative except for moderate hepatic tenderness. Gall-baldder and gastrointestinal x-rays and barium enema were all normal. Metabolic rate, blood count, sedimentation rate, serology, heterophile and urine, were all normal. Cephalin flocculation was 3 plus, thymol turbidity 8.9, and serum bilirubin 1.8. During the next two months on a routine of rest, diet and vitamins, she improved steadily from a symptomatic standpoint and all evidence of hepatic tenderness disappeared, but the laboratory tests did not begin to drop until the third month, reaching a level of thymol 1.4 and cephalin flocculation 1 plus, after four months. The patient has remained well since.

CASE FOUR

A 23-year old man suddenly developed malaise, low-grade fever, mild abdominal pain and some itching of skin. He briefly noted dark urine. Physical examination was completely normal except for a slightly enlarged tender liver. Blood count, sedimentation rate and urine were negative. Thymol turbidity was 6.6; cephalin flocculation was 3 plus; serum bilirubin was 2.1. On a routine of rest, diet and vitamins he made a swift recovery. Within two weeks his liver was normal by physical examination, he felt fine in all respects, and his tests were returning toward normal. Within one month his thymol turbidity was 3.6, cephalin flocculation 2 plus, and serum bilirubin 0.7. He has remained well since.

CASE FIVE

A 42-year old man complained of generalized aches, fatigue and weakness. Then he experienced mild soreness in the upper abdomen and felt very tearful and emotionally unstable. Physical examination was normal except for a mildly tender,

slightly enlarged liver. Basal metabolism was minus 9. Blood count, sedimentation rate, serology, heterophile antibody and brucellosis agglutinations and urinalysis were all normal. Thymol turbidity was 6.2, cephalin flocculation 4 plus, serum bilirubin was 1.1. He was placed on a routine of rest, high protein, high carbohydrate, low fat diet with vitamins. His thymol turbidity became normal in just one week, but the depression and tearfulness continued along with a three to four plus cephalin flocculation for another five months. During this time he tried to return to work on two occasions but promptly had a marked aggravation of symptoms. Finally, the cephalin flocculation became normal, the symptoms disappeared and the patient has felt well for over a year.

CASE SIX

A 64-year old business man was seen because of nonspecific malaise, fatigue, "indigestion," and bouts of tachycardia with shortness of breath. The latter had become more frequent in the preceding month along with the other symptoms. He had developed a great deal of emotional depression, which was contrary to his usual temperament. He had arteriosclerotic cardiovascular disease with auricular fibrillation and evidence of early decompensation. Diffuse tenderness of his abdomen was noted but first was thought to be due to the decompensation. Blood count, sedimentation rate and routine urine were all normal. On digitalis and diuretics, his decompensation was easily controlled. He was then given anticoagulants, and the rhythm was converted to normal sinus rhythm with quinidine. This normal rhythm has continued ever since. His abdominal tenderness, depression and fatigue continued, however, and further tests were done. Barium enema was normal. Gastro-intestinal x-ray showed only scarring from an old duodenal ulcer. Heterophile antibody test was normal. Cephalin flocculation was 3 plus and thymol turbidity was 8.0; serum bilirubin was 0.9. On the usual routine of rest, diet and vitamins he slowly but steadily improved during the next four months, losing all his abdominal tenderness and weakness. Within one month the thymol was down to four and within two months the cephalin flocculation was two plus. He has remained well for about one year.

Several similarities among these six cases are worthy of comment. All were disturbed, to some extent, by abdominal soreness and fullness. All showed positive cephalin flocculation tests and positive thymol turbidity tests, although the cephalin flocculation seemed to be a somewhat more reliable test. All quite clearly suffered from a transient hepatitis — presumably viral in nature, from which they have recovered completely, both from a clinical and from a laboratory standpoint. One of the most striking factors in each of the six, was the sense of depression and tendency to tearfulness which they demonstrated, often in sharp contrast to their previous temperament. The almost complete lack of specificity of the symptoms, coupled with the depression made the consideration of psychoneurosis very reasonable. Only the presence of elevated liver function tests and the mild hepatic tenderness served to differentiate these patients.

CONCLUSION

IT WOULD seem apparent from the medical literature as exemplified by the six cases reported in this paper, that infectious hepatitis due to a virus is increasing in frequency. It is now being diagnosed much more frequently. It also seems apparent that there must be many mild cases of hepatitis without jaundice which are simply labelled psychoneurosis. They run their course without any specific diagnosis. Barker *et al.*[17] have estimated that for every diagnosed case of infectious hepatitis, eight escape detection.

The six cases presented were all noteworthy for lack of specificity except in terms of laboratory tests. It seems advisable therefore, to think of non-icteric hepatitis in any undiagnosed illness—particularly those with a mild disease in which emotional depression is the outstanding complaint.

SUMMARY

SOME of the literature concerning infectious hepatitis with particular emphasis on the non-icteric form has been reviewed. Six cases of non-icteric infectious hepatitis have been presented. The cases were noteworthy for the considerable degree of depression which accompanied the illness. Awareness of the possibility of infectious hepatitis seems indicated in evaluating patients suffering from an illness

which is characterized only by emotional depression, since non-icteric hepatitis with a paucity of signs and symptoms is a common condition.

75 Prospect Street

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Cigarets and the Pre-Cancerous State

Dr. Oscar Auerbach, chief of laboratory service in the VA hospital at East Orange, N. J., documented a two-year study of the bronchial tree in both smokers and non-smokers to indicate that certain *changes were present more frequently in heavy smokers than in less frequent users of tobacco.*

The findings, resulting from the first large research study on human autopsy material rather than animals, were prepared by a team of six VA doctors and Dr. Purdy Stout, a VA consultant.

The East Orange team's work during the past year adds documentary proof to support an interim report made by Dr. Auerbach in 1955 that there was a relationship between cigaret consumption and the presence of abnormal cellular changes in the lining of the bronchial tubes.

In addition, the more recent study has demonstrated a similar relationship between cigaret consumption and pre-cancerous changes.

In the first phase, the bronchial trees of 41 men had been studied. During the past year, the team evaluated an additional 117 trees, enough to present accurate statistical documentation.

Of the 117 deceased, 34 (all smokers) had died of cancer.

The abnormal cellular changes were basal cell hyperplasia, stratification and squamous metaplasia, which are staging ground for cancer.

Additionally, definite pre-cancerous areas were observed. These alterations, *carcinoma-in situ*, can progress into recognizable cancer.

The incidence of all these changes paralleled the known smoking habits of the individual studied. They were encountered most frequently in the bronchi of the heaviest smokers.

Carroll M. Leevy, M.D.

Jersey City

The Liver in Diabetes Mellitus*

Although diabetes is thought of as a disease of the pancreas, it must be remembered that the liver —the body's largest gland and its metabolic headquarters—is also damaged. Indeed, liver disease may sometimes reproduce a diabetic syndrome.

The relationship between diabetes mellitus and liver disease has been the subject of many investigations since Von Mering and Minkowski [1] demonstrated hepatic abnormalities in untreated depancreatized dogs. Improved methods of studying carbohydrate metabolism in man have added much to basic information derived from *in vitro* observations. A normal blood sugar depends upon proper function of insulin and several hepatic enzymes which convert glucose into phosphorylated derivatives, glycogen, and pyruvic acid. Evidence indicates that diabetes and hepatic dysfunction frequently co-exist, and that either may be responsible for the other.

DIABETES SECONDARY TO LIVER DISEASE

Liver disease is associated with varying degrees of carbohydrate intolerance. Approximately one-third of patients with hepatic dysfunction and a normal fasting blood sugar have an abnormal curve on glucose tolerance tests, using 1.75 Grams of glucose per kilogram of body weight after an appropriate period on a high carbohydrate diet. Compound E and its analogues increase the height of these curves and may convert normal into diabetic patterns.[2] Serial studies indicate that glucose tolerance often returns to normal with subsidence

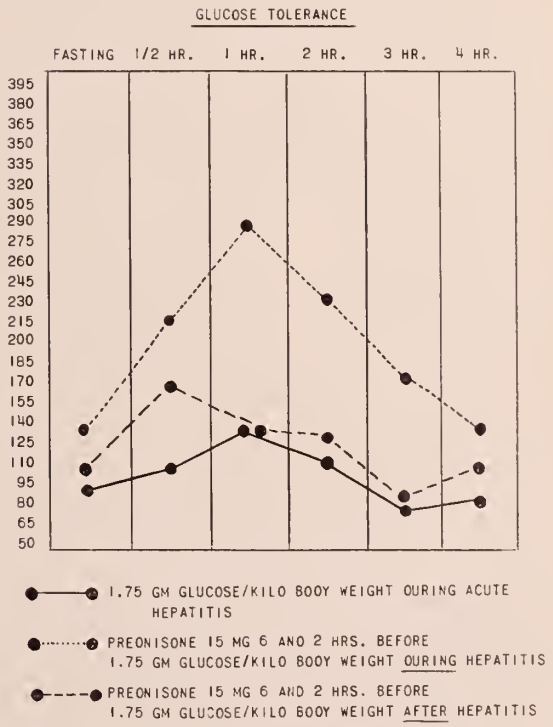


Figure 1. Influence of prednisone on glucose tolerance during and after acute viral hepatitis.

*Read at the Section on Metabolism, Annual Meeting of The Medical Society of New Jersey, May 1, 1957.

From the Hepatic-Metabolic Clinic, Department of Medicine, Jersey City Medical Center and Seton Hall College of Medicine.

1. Mering, J. Von, and Minkowski, O.: Diabetes Mellitus after Pancreas Extirpation, Arch. Exper. Path. and Pharmacol., 26:371 (1889)

2. Leevy, Carroll M.: Effects of Prednisone on Glucose Tolerance in Liver Disease, J. Clin. Invest., 36:909 (1957)

of acute liver injury (Fig. 1). Adrenal steroids given to patients with hepatic disease may precipitate clinical diabetes which disappears with improvement of hepatic reserve or discontinuation of the steroids.

Hepatic disease, on rare occasions, is solely responsible for a diabetic syndrome. This may be related to gluconeogenesis resulting from an increase in circulating hydroxycorticoids due to a selective deficiency of dihydrocortisone dehydrogenase in liver disease.[3] In the transitory hyperglycemia observed in fatty liver, an adrenal factor does not appear to be contributory and the blood sugar disturbance has been attributed[4] to interference with lipogenesis or glycogenesis, and to decreased hepatic production of humoral substances required for peripheral utilization of glucose.

Hepatogenic diabetes must be differentiated from diabetes with secondary liver injury, latent diabetes made manifest by hepatic disease, and concurrent diabetes and liver disease. We use the following criteria for hepatogenic diabetes:[5]

1. Fasting hyperglycemia and objective evidence of liver disease.
2. Onset of diabetes after development of liver dysfunction.
3. Absent familial history of diabetes, and lack of laboratory evidence of pancreatic, pituitary, adrenal, or thyroid disease.
4. Disappearance of hyperglycemia and glycosuria with improvement in hepatic reserve.
5. Normal response to the prednisone-glucose tolerance test after improvement in liver dysfunction.

The prednisone-glucose tolerance test has been invaluable in differentiating hepatogenic diabetes from latent diabetes where liver injury or other stress producing processes cause hyperglycemia. Fifteen milligrams of prednisone given two and six hours prior to a glucose tolerance test produces a diabetic curve in latent diabetes although hepatic disturbance is not demonstrated. This test,[2] advocated in recognition of subclinical diabetes, cannot be used as a diagnostic aid unless hepatic disease has been excluded. Of 12 patients in whom hyperglycemia and glycosuria disappeared with improvement in hepatic reserve, prolonged follow up indicated that 6 had hepatogenic diabetes, 4 latent diabetes, and in 2 the mechanism was obscure.[6]

Many have suggested that subclinical metabolic changes involving the liver are responsible for adult onset diabetes. This thesis is supported by: (a) the finding[7] of only moderate reduction in extractable insulin in adult onset diabetes as compared to juvenile diabetes; (b) discovery of insulinase,[8] a specific hepatic substance which can destroy insulin; (c) demonstration of humoral insulin antagonist activity[9] in the serum of the diabetic in ketosis; (d) chemical identification of glucagon[10] and elucidation of its hyperglycemia properties.

ATTEMPTS to locate the site of action of insulin, sulfonurea derivatives, phenylethylformamidinylimino urea, and other hypoglycemic agents on carbohydrate metabolism have added to the importance of the liver in the genesis of diabetes. All of our current theories on the action of insulin closely relate it to hepatic metabolism (Fig. 2). It has been suggested[11] that insulin may facilitate transfer of

3. Peterson, Ralph E.: Studies in Adrenocortical Function in Liver Disease, J. Clin. Invest., 36:920 (1957)

4. Waldstein, S. S., Ettinger, R. H., and Giges, B.: Abnormal Glucose Tolerance in Experimental Choline-Deficient Fatty Liver, Metabolism, 6:134 (1957)

5. Leevy, Carroll M.: Practical Diagnosis and Treatment of Liver Disease, Paul B. Hoeber, New York (1957)

6. Leevy, Carroll M., Fineberg, Jacob C., White, Thomas J., and Gnassi, Angelo M.: Hyperglycemia and Glycosuria in the Chronic Alcoholic with Hepatic Insufficiency. Clinical Observations in 10 Patients, Am. J. Med. Sci., 223:88 (1952)

7. Wrenshall, G. A., Bogoch, A., and Ritchie, R. C.: Extractable Insulin of Pancreas: Correlation with Pathological and Clinical Findings in Diabetic and Nondiabetic Cases, Diabetes, 1:87 (1952)

8. Mirsky, I. A., and Broh-Kahn, R. H.: Inactivation of Insulin by Tissue Extracts: I. Distribution and Properties of Insulin Inactivating Extracts (Insulinase), Arch. Biochem., 20:1 (1949)

9. Field, James B., and Stetten, DeWitt, Jr.: Humoral Insulin Antagonism Associated with Diabetic Acidosis, Am. J. Med., 21:339 (1956)

10. Elrick, Harold, Staub, Alfred, and Maske, Helmut: Recent Developments in Glucagon Research, New England J. Med., 256:742 (1957)

11. Levine, R., and Goldstein, M. S.: On the Mechanism of Action of Insulin. Recent Progress in Hormonal Research, 11:343 (1955)

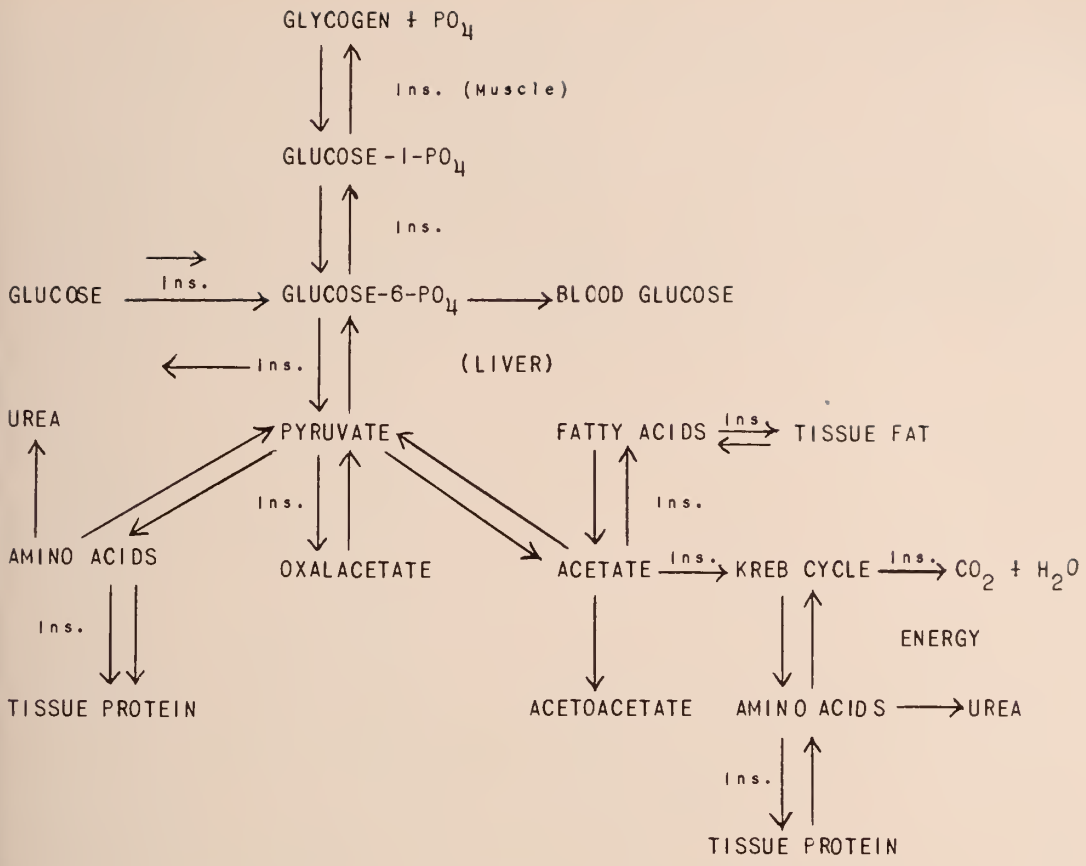


Figure 2. Insulin activity on carbohydrate metabolism.

glucose phosphate across the cell membrane; inhibit an inhibitor of hexokinase [12] which is initially responsible for phosphorylation of glucose; increase high energy phosphate formation; or influence oxidative reactions [13] in Kreb's cycle. In addition, insulin action on protein and fat metabolism has been localized to the liver. Hepatic vein catheterization has permitted study of the uptake and turnover of glucose in the diabetic subject with and without liver disease. Using this technic, diabetics have been classified [14] into insulin sensitive and insensitive types on bases of effects of this hormone on hepatic glucose uptake. Insulin sensitivity is influenced by a variety of exogenous factors including ketosis, adrenal steroids, nutritional status, and hepatic reserve.

Sulfonurea derivatives appear to lower blood sugar partly through the liver, although their hypoglycemic activity [15] has been documented in hepatectomized animals. Insulin insensitivity is accompanied by resistance to these substances. Observations from hepatic vein catheterization [16] demonstrate hepatic uptake of glucose with Tolbutamide®. An increase in hepatic glycogen is regularly noted

12. Price, W. H., Cori, C. F., and Colowick, S. P.: The Effect of Anterior Pituitary Extract and of Insulin on the Hexokinase Reaction. J. Biol. Chem., 160:633 (1945)

13. Stadie, W. C.: Recent Advances in Insulin Research, Diabetes, 5:263 (1956)

14. Bearn, A. G., Billing, B. H., and Sherlock, S.: Hepatic Glucose Output and Hepatic Insulin Sensitivity in Diabetes Mellitus. Lancet, 2:698 (1951)

15. Leevy, Carroll M.: Unpublished observations.

16. Dulin, W. E., and Johnston, R. L.: Studies Concerning the Role of the Liver in the Hypoglycemia Response of Animals to Orinase. Reprint of Conference on Effects of Sulfonureas and Related Compounds in Experimental and Clinical Diabetes, The New York Acad. Sci., February 14-15 (1957) pp. 12-13

following its administration.[17] It has been suggested [18] that decreased hepatic gluconeogenesis may contribute to observed hypoglycemia.

Study of carbohydrate imbalance in hemochromatosis provides additional information on hepatic metabolism and diabetes. In this disease, iron deposits in the islets of Langhans decreases the production of insulin, and hepatic dysfunction interferes with its utilization. There is often an increase in histologically detectable iron in the fatty liver of diabetics,[18] and removal of hepatic iron in hemochromatosis by phlebotomy may decrease insulin requirements.

DIABETES WITH SECONDARY LIVER DISEASE

ALTHOUGH the relationship of liver disease to diabetes mellitus may be debatable, the ever-present altered hepatic metabolism in diabetes is well established. *In vitro* studies [19] show negative nitrogen balance, decreased lipogenesis and interference with Kreb's cycle.

Clinical studies show a high incidence of abnormalities of liver function tests. Among 380 unselected diabetic patients in the Jersey City Medical Center,[20] 38 per cent had hepatic dysfunction. The incidence increased with intercurrent complications such as infections, diabetic coma, and peripheral gangrene. Postmortem studies confirmed the high incidence of hepatic lesions. Of 127 diabetic patients studied at autopsy in our clinic, hepatic disease was present in 20 per cent (Table 1), twice the incidence of hepatic abnormalities in a control group.

TABLE 1. PATHOLOGY OF DIABETES MELLITUS IN 127 AUTOPSIES, J.C.M.C.

Pancreatic Abnormalities:	
None	102
Hyalinization	18
Pancreatitis	5
Hydropic degeneration	2
Hepatic Abnormalities:	
None	97
Fatty	10
Cirrhosis	15
Focal necrosis	5
Renal Abnormalities:	
None	46
Nephrosclerosis	30
Intercap. glom. sclerosis	26
Pyelonephritis	19
Necrotizing papillitis	5
Glomerulonephritis	1
Coronary Abnormalities	65

The diabetic patient may develop intercurrent viral hepatitis, biliary obstruction, or hepatic changes due to heart failure; however, nutritional deficiency is responsible for most instances of liver disease. The diabetic patient is similar to the insulin maintained depancreatized dog in that lipotropic deficiency produces a fatty liver and eventually leads to cirrhosis.[21]

Dietary deficiency coupled with glucose wastage and negative nitrogen balance contributes to fatty liver. Serial biopsies in poorly controlled diabetic patients have demonstrated transition of fatty liver to cirrhosis in the absence of other contributing factors (Fig. 3) The exact mechanism for fibroblastic transformation of the fatty liver is not known. Development of fatty cysts with their rupture and the accompanying inflammatory reaction and condensation of reticular fibers is a precursor of fibrosis. Fibrosis and nodular regeneration of liver cells distort the normal lobular pattern of the liver. These morphologic alterations interfere with biochemical processes which are necessary for phosphorylation of glucose. In addition, rupture of fatty cyst

17. Renold, A. E., Winegrad, A. I., Froesch, E. R., and Thorn, G. W.: Studies on the Site of Action of the Arylsulfonylureas in Man, Metabolism, 5:757 (1956)

18. Zimmerman, H. J., MacMurray, F. G., Rappaport, H., and Alpert, L. K.: Studies of the Liver in Diabetes Mellitus I. Structural and Functional Abnormalities II. The Significance of Fatty Metamorphosis and Its Correlation with Insulin Sensitivity, J. Lab. and Clin. Med., 36:912 (1950)

19. Villee, C. A.: Intermediary Metabolism, New England J. Med., 251:21 (1954)

20. Leevy, Carroll M., Ryan, Charles, and Fineberg, Jacob C.: Diabetes Mellitus and Liver Dysfunction. Etiologic and Therapeutic Considerations, Am. J. Med., 8:290 (1950)

21. Best, C. H., Hartroft, W. S., and Sellers, E. A.: The Protection of the Liver by Dietary Factors, Gastroenterology, 20:375 (1952)

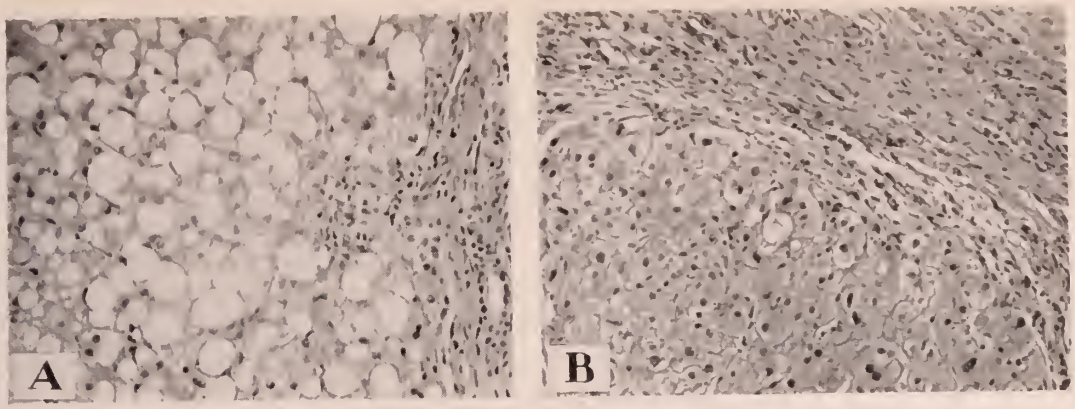


Figure 3. Transition of fat to cirrhosis in poorly controlled diabetic patients. A. Fatty liver, 1948; B. Moderate cirrhosis, 1957.

may cause fat embolism[22] and thereby contribute to degenerative renal and cardiovascular lesions in diabetes.

TREATMENT

TREATMENT of diabetes associated with hepatic dysfunction depends upon their etiologic relationships. Restoration of nutritional and metabolic balance in such patients is of paramount importance. When diabetes is due to hepatic disease, hyperglycemia and glycosuria disappear with improvement in hepatic reserve. Rest, a moderate carbohydrate, high protein diet, and vitamin therapy is indicated. It may be necessary to restrict protein intake in patients with severe liver disease to prevent ammonium intoxication. Glycosuria is readily controlled with either insulin or arylsulfonurea derivatives.[16]

The value of insulin in these patients is well established. In our experience, arylsulfonureas have also been effective in patients with hepatogenic diabetes as well as in those with latent diabetes made manifest by hepatic injury. Theoretically, these agents may be the drug of choice because of their ability to increase hepatic glycogen. This is illustrated by a 50-year old man hospitalized because of alcoholism and tender hepatomegaly. He had a hyperglycemia and glycosuria which disappeared on Carbutamide® and a 300 Gram carbohydrate, 100 Gram protein, 100 Gram fat diet (Fig. 4). Liver biopsy showed fat which was mobilized with this therapy. Post-therapy glycogen studies showed an increase in hepatic glycogen over control levels. A subsequent prednisone-glucose tolerance test was normal.

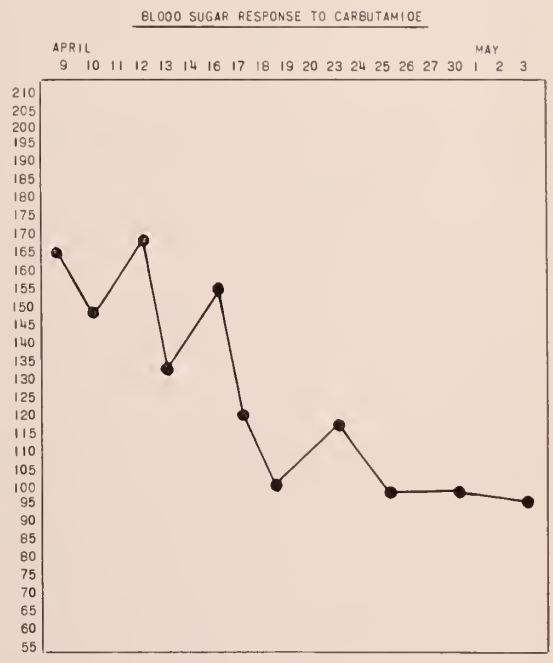


Figure 4. Response of blood sugar in hepatogenic diabetes to Carbutamide and diet.

22. Hartroft, W. S., and Ridout, J. H.: Pathogenesis of the Cirrhosis Produced by Choline Deficiency, Escape of Lipid from Fatty Hepatic Cysts into the Biliary and Vascular Systems, Am. J. Path., 27:951 (1951)

Patients with known latent diabetes, made manifest by acute liver injury, should receive a relatively high carbohydrate, high protein diet, with insulin or sulfonureas to control hyperglycemia and prevent further pancreatic damage. Adequate control of diabetes is also essential when liver disease is secondary to carbohydrate imbalance.[20] Diet and insulin control both blood sugar and hepatic abnormalities in most of these patients. Occasionally, marked insulin resistance is present. A study employing Tolbutamide® in patients with diabetes and secondary liver injury is now underway in the Jersey City Medical Center to determine the results of prolonged use of this drug on biochemical and histological changes.

SUMMARY AND CONCLUSIONS

1. The liver, which is the metabolic center of the body, is always damaged in diabetes mellitus. Occasionally, liver disease may be responsible for a diabetic syndrome which will disappear with improvement in hepatic reserve. This may be due to disturbances of hepatic regulation of blood sugar or latent diabetes made manifest by liver injury. The prednisone-glucose tolerance test is helpful in determining which mechanism is responsible.

2. Abnormality in carbohydrate, protein and fat metabolism due to an insulin insufficiency is accompanied by a high incidence of liver dysfunction, fatty liver, and nutritional cirrhosis. Hepatic changes should be prevented by adequate control of hyperglycemia and glycosuria and attention to general nutrition.

3. Insulin, vitamins, and a well-balanced diet are adequate therapeutic measures in most patients. Preliminary observations demonstrate that diet and oral sulfonamides are effective in control of both sugar metabolism and hepatic abnormalities in hepatogenic diabetes. Further studies are required to determine the usefulness of these and other non-insulin hypoglycemic agents in the diabetic patient with secondary liver injury.

The Medical Center

Therapy for Stingray Injuries

Immersion in ice water (cryotherapy) is the most effective method for treating painful stingray wounds, according to a report by a trio of Galveston physicians.*

Among the 21 patients treated pain was completely relieved in 20 minutes in 18 cases where cryotherapy alone was used. Two patients receiving only partial relief in 90 minutes were treated with the use of ice packs. One who received only opiates experienced partial relief in 2 hours. "The ice pack or chilled water did not accomplish the same result as the foot immersed in a heavy suspension of ice and water."

One of the most excruciatingly painful wounds inflicted on man by any animal is that of the stingray. This is a common hazard to sea-bathers and fishermen.

Treatment consisted of immersing the involved extremity in ice water to a depth of six inches above the wound site. The original temperature of the water is 0°C., but once the extremity has been placed in it the temperature rises to 5°C. In the majority of cases it is necessary to maintain this immersion for one and a half hours. Pain is reduced in five minutes, and during this time the patient has marked discomfort from the cold water. The pain of the puncture wound is completely relieved within 20 minutes in most cases. "This has not been attained previously by opiates."

A further advantage is that it can be carried out as a first-aid method, since ice and some type of container usually are available along the water front.

*Mullins, J. F., Wilson, C. J. and Best, W. C.: Southern Medical Journal, 50:533 (April) 1957.

Samuel A. Goldberg, M.D.
Newark

Abdominal Fluid

Third of a series prepared by the Cancer Control Committee of The Medical Society of New Jersey.

Sometimes the first evidence of neoplasia is the presence of ascitic fluid. In benign conditions the fluid is usually clear, yellowish, resembling serum, of a low specific gravity and a low protein content, except in peritonitis. In peritonitis, the fluid is cloudy with a high specific gravity and increased protein content. In neoplastic invasion the ascitic fluid may be blood tinged or clear, often of a high specific gravity and a high albumin content.

For microscopic examination of the sediment, send all of the collected ascitic fluid to the laboratory, not just a sample of it.

In preparing the fluid for microscopic examination all of the fluid should be centrifuged. After settling for 30 minutes, half of the fluid should be decanted and if necessary an equal amount of formalin be added. Then, it may stand overnight. After centrifuging, part of the sediment is smeared on a slide and stained. The remainder is embedded in paraffin, sectioned and stained as a tissue.

Microscopically, we often see particles of various types of tissue in glandular formation or in groups indicating papillary structures. There may even be groups suggestive of nests of cells. In these instances the diagnosis is relatively simple. If only individual cells are seen the diagnosis is not so easy.

In benign conditions we note occasional lymphocytes, endothelial cells, a rare neutrophile or a histiocyte. If the fluid has been there for any length of time, proliferative changes take place in the endothelial cells so that they may be mistaken for neoplastic cells. In general, neoplastic cells are larger. In some the nuclei are eccentric and the cytoplasm contains mucin. The nuclei are larger compared to the size of the cell, than in the benign endothelial cells. They are hyperchromatic. The nucleo-nucleolar ratio is larger, as a rule. Occasionally we see a mitotic figure even in proliferating mesothelial cells. Masses of lymphocytes may be due to malignant lymphoma. Mucin-containing cells, extremely large cells with extreme hyperchromatism, may indicate anaplastic carcinoma of ovarian or gastrointestinal origin. Neoplastic cells in papillary formation may indicate an ovarian origin, from papillary cystadenocarcinoma. Groups of cells in glandular formation may indicate peritoneal metastases of a gastrointestinal or ovarian carcinoma. Generally a definitive diagnosis from ascitic fluid is very difficult and in order to come to a definite conclusion all of the factors must be considered, including the history, clinical findings, as well as cytologic study of the ascitic fluid.

SUMMARY

All of the fluid collected should be sent to the laboratory. Factors taken as criteria for neoplastic cells may be found in non-neoplastic ascitic fluid. Thus, we may see pseudoacini or endothelial cells with excentric nuclei. Cytoplasm resembling mucin, may be phagocytized fat particles, pushing the nuclei aside. Large nucleoli and rare mitotic figures may also be seen in benign mesothelial cells.

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Psychiatry and Public Health*

Most of today's psychiatrists were trained to think of emotional disease as an individual problem, an intrapersonal problem in the most intimate sense of the word. The more sophisticated psychiatrists now know, however, that mental disease is a public health problem, and that psychiatry is, in a sense, a social science.

Very early in my career as a psychiatrist —and as my interest in public health was beginning to bud—I became aware of the work of Dr. Julius Levy and I came to New Jersey to talk with him. I particularly observed his work in the education of public health nurses —in teaching these nurses to be more effective in educating mothers about personality growth in children. Dr. Levy's idea of "anticipatory guidance," as he so neatly put it, became an important concept in the development of the then new field of public health mental hygiene.

I have been chosen to speak as the C. C. Beling memorial lecturer here. I am honored at the choice. Dr. Beling was a pioneer in the practice of psychiatry in the community, as distinguished from intramural psychiatry. He kept open the channels of communication between psychiatrists and their medical brethren. While this is a commonplace today, it was no mean accomplishment in the first few decades of the century when psychiatry was so much more isolated. Dr. Beling's accomplishments in weaving cables of communication which then could hold and draw closer to the specialty of psychiatry to the broad area of the practice of medicine in the community are a contribution well known to New Jersey physicians.

This is an age of communication between scientific fields, one in which the borderlands between branches of science have become more and more indefinable. Physics and chemistry found it so necessary to get together that a new specialty came about, called physical-chemistry. Physics and astronomy combined to be astrophysics. The enormous industrial development of electrochemistry opened many new doors toward making new combinations of metals to serve us better. The combination of fields of science becomes even more necessary when we cross to the study of living material. Here we find biochemistry, biophysics and physiologic chemistry. In the study of the central nervous system, this need for combination has been most apparent, so that nowadays it is difficult to find a neuro-anatomist who is not also a neuro-physiologist. In this technical age, such a man will probably be an expert in electronics as well in order to carry out his investigation.

Very few research problems which relate to human beings and their behavior can, in these days, be solved by a single individual. Almost all seem from the very beginning to require combinations of skill beyond those which one

*Read by invitation November 20, 1957 before the New Jersey Neuropsychiatric Association meeting at the Veteran's Administration Hospital in East Orange. This was the Association's eleventh annual C. C. Beling Lecture.

man can have and must thus be carried out by a team of investigators rather than a single individual. Sometimes I think that our devotion to the idea of team research is based not so much on the conviction that a combination of skills is necessary to solve the problem, but rather on the unwillingness of one or another individual to accept responsibility for trying alone to solve it. Sometimes, perhaps, we look to a team because we do not wish to do the work necessary to become expert in one or another technic of investigation. Perhaps we do not want to put the time in on study so we hire someone else to do it. Then we may have to spend even more time to achieve a basis of communication between the two investigators than it would have taken to educate one or other in both the fields fundamentally necessary to do the research. But the subject matter for the evening is not communication and its problems, interesting as they are, but rather to examine the relationships which have grown up between these two great fields of health-endeavor within the general fold of medicine: psychiatry and public health.

THE MISSION OF PUBLIC HEALTH

Like psychiatry, public health is very practically oriented. It has a job to do for society and for the most part it keeps its eye on that job rather than on far-flung, theoretic developments which appear to have no immediate practical value. Like psychiatry, public health draws its major financial support from the public coffers and is thus constrained to show its results, or if not results, its activity designed to and hoped to produce worthwhile results.

Public health is that branch of medical science which attempts to apply the results of clinical and laboratory research to total populations. It attempts to cut the time lag between a new therapeutic or preventive idea and its widespread application. Because its work is frequently concerned with large numbers of people, public health research has frequently been of the character of how to multiply the application of a discovery so that it may be economically—but, particularly, safely—applied to a whole population. It has thus been concerned not only with the development of safe agents to immunize populations against particular diseases, or rapid means of determining contamination of a source of food supply; it has also always had a major concern with the problem of education of staff people who might safely apply a new procedure or product across the whole of a population.

It has often been said that public health is concerned only with the well and with efforts to keep them well. To some degree this statement is true and perhaps this should be the function of an ideal public health agency. But as I said earlier, public health is a practical field. It is a field for *application* and as such it must respond to the needs of a population, be they preventive or therapeutic. The very present danger to the population that an active, open case of tuberculosis presents is a clarion call for action on the part of public health agencies.

To protect the public from the active open case of tuberculosis requires the hospitalization, the segregation, of the sick person. The burden of this sort of hospitalization and therapeusis is generally considered a public health responsibility. In earlier days, when infectious epidemic diseases were more dangerous than they now are, there were many more situations resembling the tuberculosis case, in which the removal of the infective agent, the person, was of prime importance. In order that he might be removed in the most humane manner, he had to be treated. The treatment function fell to the public health agency. A decade ago, the treatment of syphilis was of prime importance in public health practice since the goal was to get treatment as rapidly as possible, to as many cases of syphilis as possible, in order to stop the progression of the almost chronic epidemics of that disease in our population. The economics of the situation was such that the *grouping* of patients was necessary to insure adequate treatment. This grouping, in turn, involved administrative problems which brought the treatment of syphilis into the orbit of public health prac-

tice. It is probably unnecessary to point out that the actual treatment was carried out by local practicing physicians. The public health agency organized the patient load and discovered the patients so that treatment might reach them in the most efficient and economical way.

THERE is a tendency to think of public health efforts as having a very short history, as though there were nothing in the field preceding the proof of the germ theory of disease. This, of course, is far from true. The social problems of leprosy, tuberculosis, the great plagues, cried out not only for the means to stop these scourges, but also means for relieving the patients if the diseases could not be stopped. These cries were raised and were responded to by organized efforts of society long before the germ theory was proved. Doctors have always been held responsible for failure of health in populations and, when the catastrophe becomes very great, public order must be introduced to see to it that medical care is administered with maximal efficiency. These earliest care-taking functions of government, these organizational plans for use in catastrophes were part of society long before the beginning of the century of progress following the proof of the germ theory of disease.

It is natural that as soon as effective preventive measures against some of the major scourges were available, that these ancient care-taking functions of government would be eclipsed by the bright and rising star of the *prevention* of deaths. The problem of laboratory diagnosis became so important to the safety of the body politic that public health agencies became responsible for the operation of the laboratories themselves, and during the heyday of this development, actually manufactured many of the immunizing materials which were so important. Most of this manufacturing and developmental function has now passed out of public hands and back to private organizations who maintain the standards of preparations satisfactorily and who can afford to sell them at a reasonable price. Few public health laboratories are now manufacturing centers although the diagnostic function has remained with them to a quite considerable extent. The public health department still is, to a considerable degree, the distribution agent for many immunizing preparations.

THE CONCEPT OF PRODUCTIVE DEATH

YOU may wonder why I have felt it necessary to go into so much detail about the developments in public health. My reason is that I wish to make it plain that public health does not proceed from an overall theoretic point of view, but rather that it reacts to social demands upon it with such knowledge as is available at a particular time and that it is dedicated to the proposition that this knowledge be crystallized in some form which would as nearly as possible reach the needs of all the people in the population. I make this point to proceed to my next one which is the modern concern of public health with the "productive death" of an individual as contrasted to his biologic death. Causes of death are changing radically. The great killers of the past have come under control. New types of causes of death now dominate the picture. Diphtheria, typhoid, pneumonia, tuberculosis, even, now kill much more rarely; whereas accidents, cancer, suicide and heart disease have become the major killers.

This change in causes of death implies more than a mere change in the order of diseases in the column of causes of death. There is a difference in what the major causes of death in this day *do* to people and what the causes of death of an earlier period *did* to people.

For the most part the great epidemic diseases were "kill or cure" propositions. If you got well of diphtheria, you were likely to be completely well. If you got well of pneumonia, you were likely to be completely well. And if you didn't get well, you died and were out of the picture. This is not true of the diseases which now lead the roster of causes of death. Rarely can we speak of *cure* of heart disease; most of the time we speak of recovery from an acute decompensation, implying that we have made no significant change in the underlying pathology of the heart. Similarly, it is

frequently the case that an accident, if it does not kill, will result in a period of convalescence of some length, and frequently a decreased capacity to produce thereafter by reason of a prothesis or some other disability as a result of the accident. It is possible to prevent death from diabetes, but the cost of the prevention is the continuous treatment of the patient to keep the disease under control. We do not cure it.

To some extent, the same kind of situation prevails in cancer. Those illnesses which, today, are the major causes of death, produce many "productive deaths." This phrase describes the removal of the individual from the productive force in the population a considerable time before biologic death occurs. There is, thus, the reduction of the person for a period of time from being a lively producer to being a passive consumer of the productive energies of others. In its practical way, public health has had to reorient itself so that it can face problems of diseases which do not produce biologic death immediately, but which produce the socially "productive death" of the individual. Public health has begun to struggle with the organization of methods of management of these diseases which produce morbidity frequently long before they produce mortality; which produce social death, productive death, rather than biologic death at once. You are all familiar with the efforts to establish case-finding methods for diabetics, cancer detection clinics, public education as to accident prevention, epilepsy programs and rehabilitation efforts for cardiac patients—all these are evidences of the recognition by public health agencies of the practical necessity to divide attention more equally between the ancient enemy of epidemic disease and these killers which have emerged from ambush only after the victory over the infectious diseases had been, to a great extent, already won.

THE MISSION OF PSYCHIATRY

Now, let us turn from public health and look at psychiatry. It also has a very practical mission to perform in society, a mission it has carried out over the centuries. Psychiatry has been called upon to relieve society of persons whose behavior was such that it disturbed the social order, disturbed the comfort of the population. While psychiatric patients have never compared in dangerousness to patients with open tuberculosis lesions, they have been easier for the "man-in-the-street" to spot, and have disturbed him more, made him want to get them out of the way, out of his presence. Psychiatry has been the specialty of medicine that has responded to the demand that this group of persons be taken care of in as humane a way as possible. Because it has had to respond to public demand, and has, to a very large extent, been publicly supported, psychiatry has been bound by the same kind of practical considerations that have already been detailed for the specialty of public health.

Psychiatry has not had the good luck to happen upon so successful and economic a method for dealing with a large segment of its problems as had public health through the development of the germ theory of disease and the discoveries it presaged.

Psychiatry is a practically oriented specialty, as is public health. Like public health, it has had to respond to the voiced needs of the population for particular medical services. It has had to respond to society's needs for the treatment of certain kinds of diseases even though it had few specific moves to make in the direction of cure. The public health officer once built fires in the streets to stop the plague and drained swimming pools to stop poliomyelitis, even though he had no invulnerable logical rationale for doing these things. Like him, the psychiatrist also has had to attempt to treat and prevent diseases, though for some he lacked a clear cut rationale in doing so. He has had to do this for many centuries.

I have said that psychiatry has not been as fortunate as public health in having presented to it a scientific discovery that made possible the control of what formerly were its most fundamental problems. Perhaps this is an overstatement of the situation; perhaps it would better be said that psychiatry has not recognized the fact that such discoveries have

been of great aid to it. The control of syphilis which has brought paresis so well under control; the virtual disappearance of the mental disease, delirium; the control of the pellagra psychosis—these have all been distinct and important steps in the prevention of psychiatric illnesses. They are, however, frequently lost sight of because our most overwhelming problem, schizophrenia,* has not yielded—has not yet revealed how it may be prevented and treated. We have not seen a radical change in the order of causes of "productive deaths" in our field. Schizophrenia still remains in the foreground. What I am trying to say is that psychiatry has not had the adaptation to make, has not had to reorient itself from one kind of death to another kind of death. We have been faced continuously with the problem of morbidity, of loss of productivity, as our major problem. Unlike public health, we have not had radically to change our outlook. We have gained an ally. Public health comes to stand side by side with us in considering the problem of loss of social productivity as a major problem of our society.

THE NEWER PSYCHIATRY

ALTHOUGH psychiatry has not faced as radical a change in its problems as public health has, new influences have come to play upon it which have been of tremendous importance. These have been taking place concomitantly with the control of mortality producing diseases. Let us examine what some of these changes have been.

You are all familiar with the ancient concepts of the workings of fate, possession by demons, *et cetera*. We still can see the tail end, I hope the tail end, of this period in constantly diminishing form in the persistence of the ideas of stigma associated with psychiatric disease. Better education, both of the public and of physicians, yea, even within the psychiatric specialty itself, will further reduce both the feeling of stigma and the conviction of inexplainability (or inability ever to understand) what psychiatric diseases are and how they may be prevented and cured. The New Jersey Association for Mental Health, together with similar divisions of the National Association for Mental Health, has done much in achieving both a decrease in the feeling of stigma about mental illnesses and toward increasing an appreciation that they are diseases subject to research as are all other illnesses.

The overall effect of the modern concept of causation in psychiatric illness has been this. It has changed the ratio of the importance of the individual to the importance of the factors playing upon him as he proceeds through life. There was a day when the development or non-development of a psychiatric illness was considered to depend almost entirely upon the *internal* resources of the individual concerned, with what his heredity pattern was and on what kind of constitution he had received as a "given" at the beginning of his life. As time has gone on, more and more attention has been drawn to the factors which mold and change an individual during his lifetime. We have come to recognize that the basic capacities, the inherent stuff of which the individual is made, is tremendously affected by a great many influences during life experience.

Many of these influences derive from the interpersonal relationships in the course of a life history. It is to these that I wish particularly to draw your attention. To work with them we will need some of the skills which have been peculiar to public health if we are to reach satisfactory ways of affecting total populations.

INTERPERSONAL RELATIONS

INTERPERSONAL relationships have much to do with the development of personality and the molding of the individual, so that he is psychiatrically healthy or vulnerable to psychiatric illnesses. We immediately face the problem of how and where we can best study these

*Actually, senile psychoses now exceed schizophrenia in accounting for beds in our public mental hospitals. However, most of the senile psychoses occur in patients beyond the productive period, whereas schizophrenia characteristically strikes at the peak of a man's productive life. So in terms of "productive life," schizophrenia is the number one public health problem in psychiatry.—*Editor.*

social factors so that we might understand them better and learn to influence them in the direction of increasing the mental health, or protecting the mental health, of the population. If we are to study such factors, we shall have to study them where they exist. We shall have to study them in the homes of the people—we shall have to study them in the small group organizations of people—we shall have to study them in Girl Scouts and Boy Scouts and Cub Scouts and Brownies—we shall have to study them in the Sunday School class and in the church service. We shall have to study them in the nursery school and the public school. We shall have to study them in situations where stress is apparent: in the doctor's office, in the welfare department, in the family case work services, in the prenatal clinic, in well-baby facilities. We cannot study them only as they appear as end results, hidden under many layers of pathology such as we see in our chronic patients in mental hospitals. If psychiatry is really to test its newer theories about the influence of interpersonal, social, experience on the developing personality and on the incidence of some of the mental diseases, then we shall have to get psychiatric services into the community, and psychiatric researches into the community. Now this is all very well on a theoretic basis, but it is a *practical* necessity as well. We are, in psychiatry, practical people as well as theoreticians.

Most of us believe that psychiatric illnesses, like other illnesses, respond better when treated early. It is better to deal with a case where it is rather than remove it to another place and treat it there. On occasion, I have expressed it this way: it is better to prevent *de*habilitation than it is to do *re*habilitation.

We must get both our therapeutic and preventive efforts into the places where the presumably causative relationships are brought to bear. We must influence these relationships when they are occurring, and we must set ourselves not only to influence the immediate relationships, but also the broad setting in which it takes place.

I have a feeling that what I have been saying has a kind of "individual language" tinge which may make it difficult to grasp my meaning. I may be failing to communicate what is really in my mind. Perhaps an illustration will help. If we are really to influence mental health for the better, our efforts will penetrate somehow into the intimate life of the home. But they must also cover such tremendous social and political problems as the rehabilitation of a slum in a city. Slum conditions must be corrected, not only because they are the source of tuberculosis and other respiratory diseases and many other ills of mankind, but also because they are frustrating to human beings—so frustrating that eventually they may break the morale of an individual so that he no longer hopes for something better for his children than he, himself, has. If the morale of the adult is gone, his relationship with the child tends to stultify rather than to expand the child's personality. The cloud of frustration envelopes the whole family and the personality of the child germinates in the stultifying atmosphere of the frustration of the mother, of the father. But this does not mean that the only way of attack on the problem is the removal of slums. The child has not experienced the frustration of the slum—he experiences the effect of the frustration of his mother. If the mother's morale can be upheld even under the slum conditions, then the child will not be engulfed in this cloud of frustration which I have used as an image. The mother will, as it were, act as a windbreak to hold the cloud back and the child can develop in a healthy morale situation, even in the midst of the generally unhealthy slum situation.

Thus we introduce the social worker, the public health nurse, the skilled day-care-center or nursery-school teacher, the skilled public school teacher, attempting to make use of these people to bolster morale—in order to promote the best kind of interpersonal relationships that are possible under the circumstances. I tremble as I voice these ideas. They are enormous—they involve all of the people. They

involve politics—they involve education—they involve health. They involve community organization of an order as yet almost undreamed of. And yet they must be carried out with complete respect for the individual, and for his right to choose what kind of life he wants to lead. They cannot be fascistic, they cannot be autocratic; they must be matters of choice, they must be matters of leadership and followership rather than forced acquiescence to one or another way of life.

THE COMMUNITY SETTING

Now to return to the very practical considerations from which we started. This means that for maximum effort—maximally efficient effort in psychiatry—we shall have to move very rapidly from our closed hospitals to the community. We shall have to have agents in the community to serve the population according to the needs it has at a particular time.

The ideal of full community service for cases of mental ill health is fairly well formulated. It includes early detection of ill health and the application of corrective influences. Yet we find in epidemiologic studies of mental deficiency that the ages at which most cases are reported are 13 or 14. Mental deficiency is diagnosable far earlier than this and corrective influences which might avoid the complications secondary to neglect of the condition can certainly be applied earlier than this. A study in the Los Angeles schools reported to the American Public Health Association in November 1957, indicated that behavior problems in the school also had their maximal number of cases at age 14. Surely many of these had been present for many years also, and were, by the time they were reported, heavily overlaid with habit patterns of reaction which made treatment far more difficult than it might have been earlier.

To get this earlier reporting we must have agents in the field to find the cases earlier. Who shall these agents be?

It has been suggested that they should constitute a whole new community organization, a county or city mental health department, with a county mental health officer, mental health nurses or social workers and all the other types of professional and non-professional personnel necessary to care for what I have sometimes characterized to my public health colleagues as "the other half of the patients."

But actually the patients cannot be divided into the halves so neatly; categories overlap, the mentally ill are very frequently physically sick and the physically sick are often emotionally disturbed. Separating them for services seems impossible both theoretically and practically. Furthermore, the building of a new organization of mental health community workers in addition to the health resources now available is financially unthinkable. Most governing bodies would refuse to consider the enormous cost of duplicating the health department and social welfare agencies by adding special, separate mental health agencies that might be large enough to penetrate into the community as far as can those services just mentioned. It would appear that both from the theoretic and the practical points of view, we will be wise to enlarge the scope of presently active field personnel so that they add mental health objectives more fully to the health and social problems they now deal with. As health, social, educational, and other services penetrate the community to the level of the relationships within the home, they can become purveyors of mental health as they are presently purveyors of other health services and of social health and social therapy. Were this fully possible it would be quite safe to abandon the concept of a whole new group of personnel designed to meet mental health needs.

Health, social and educational work has always rested upon the ability to influence attitudes. The addition of mental health aims in the work of persons in those fields is, for the most part, more than the adding of new responsibility. It involves also the sharpening of skills in attitude-changing and modification. This may well have the added effect of increasing the efficiency with which the original task of the worker might be accomplished.

The promotion of health has always involved the kinds of factors that I spoke of earlier as important in the newer theories of psychiatric etiology. Some conditions undermine the resistances of the population to any sort of disease. It is not remarkable to find that many of our psychiatric cases are found in the so-called lower-economic classes. The improvement of general living conditions for the population, both by the radical change of the physical environment, and also by the change in the intimate life within the family has been an aim of public health for many generations. I believe that in this generation, as public health mobilizes its resources to deal with the prevention of "social and productive death" through psychoneurosis, through cardiac disease, cancer, diabetes, schizophrenia, arteriosclerosis, we shall be able to increase our health promoting, disease preventing, and our efforts to cure tremendously.

For our purposes, public health can offer its skills and it can expand the capacities of its personnel to deal more and more with the problems of intimate living and its relation to disease. The hard won skills of training personnel to change attitudes of families and individuals so that health may reach its optimum may be used. Even more, the administrative skills, how to get communities and their agencies to work together toward a common good, may be utilized as psychiatry penetrates with its preventive and curative services to the essential level of interpersonal relations within the home.

On our part, we can extend to public health some of our hard-earned knowledge about how people live and work together in the emotional area. We can make our contribution in the education of personnel in the ways of deepening and making more effective methods of interviewing in attitude-changing, attitude-modification. We can present the problem of early case finding and we can ask our colleagues in public health to help us organize our efforts so that we reach the maximum number of the population with the maximal possible impact.

I do not deny that this is a dream. As a teacher for many years, I know how hard it is to educate. Having been somthing of a political administrator, I know how hard it is to change the social order. I know how deficient we are in researchers and in treatment personnel in psychiatry. I would not for a moment advise the ceasing of efforts to repair these great flaws. On the other hand, I would like to point out that we do not stand alone. Our colleagues in the field of public health have approached the problem of "productive death" by another road. But they recognize that we must deal in this day and age not only with people who die but with people who stay sick, who are in a condition of morbidity, whom we wish we could get back into the productive pattern of society. These colleagues, even if they wanted to, could not reasonably reject the psychiatric illnesses as a basic concern to themselves, as they strive to prevent morbidity. Nor will their own research justify any rejection of the social causation of disease—of the recognition that influences upon the individual mold and formulate his health —psychiatric health — organic health — social health. Our colleagues in public health have personnel which has entré into many of the areas where we must go, into the intimate home life, not only for effective work but also for much of our research. We must recruit the public health nurse as a mental health worker. We must recruit the school teacher, the social worker also.

We are not separate philosophically from public health. Both of the specialties are practical specialties; both have a job to be done. Both recognize the interpersonal factors in the causation of disease. Let us then march together toward the high goal of preventing the psychiatric diseases and promoting good general health.

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Diagnostic Evaluation in Osteoarthritis*

If you are over the age of 50, the chances are 4 to 1 that you, too, have osteoarthritis. So says Dr. Edwards in this brief rundown of diagnostic aids.

OSTEOARTHRITIS is a common chronic joint disorder of adult life that results from the stress of wear and normal aging in joint tissues. It is the commonest degenerative disease involving eighty per cent of all people over the age of fifty.[1] One out of ten seeks medical advice because of pain and stiffness of his joints.

Concerning the aging, Hollander[3] has very appropriately stated that osteoarthritis is to the joints what arteriosclerosis is to the blood vessels.

This "wear and tear" type of disease has been defined as a nuisance disease to both the patient and the physician. The patient is annoyed because of joint pain and stiffness in spite of his excellent general health. The physician is chagrined because of the progression of irreversible degenerative changes of worn joint tissue in spite of his best therapeutic measures.

Contributory factors besides the wear and tear of aging are:

(1) Trauma to joints
(2) Obesity
(3) Occupational stress
(4) Poor posture
(5) Anatomic derangements and congenital defects
(6) Menopause

Our diagnostic aids are the essentials of physical diagnosis. Namely:

(1) History
(2) Physical Examination
(3) Laboratory studies

Bayles[7] says that a good history is one of the most important elements in the diagnosis of osteoarthritis.

A family history may reveal the presence of Heberden's nodes as a hereditary factor. Stecher's study[9] of this disease indicated that it was genetically transmissible as a dominant trait in women and a recessive one in men.

A past history portrays the importance of trauma in the localization of a lesion. A pattern of localized symptoms with x-ray findings is a prerequisite for diagnosis.

Prodromal symptoms consist mainly of pain and stiffness. The characteristic pain of the osteoarthritic joints is pain which occurs primarily with use or overuse of the involved joint and is relieved by rest. The onset of symptoms is usually very gradual unless precipitated by trauma.

The joints involved are, commonly, the fingers, cervical spine and knees in women and the lower spine and hips in men. Synovitis is rare unless the joints are acutely traumatized.

Systemic symptoms are rarely found. Laboratory studies are usually within normal limits.

Under "Physical Examination" let us con-

*Read at the Rheumatism Section, Annual Meeting, The Medical Society of New Jersey, May 1, 1957.

sider the specific joints. First consider the *fingers*. Heberden's nodes are usually considered a manifestation of this form of arthritis. Trauma of occupation and sports explain some of the cases. They may appear insidiously after menopause. The nodes are more unsightly and clumsy than painful.

The *hands* are of *specific* diagnostic importance because of the absence of involvement of the metacarpal phalangeal joints. Lockie [6] cannot recall a single instance in approximately 4,000 patients where there was involvement of the metacarpal phalangeal joints. This suggests that, if arthritis is present, it probably is rheumatoid arthritis not osteoarthritis.

Now the *spine*. Degenerative changes of the cervical spine may reveal symptoms of localized aching or stiffness, neuritis and paresthesias of the shoulders and arms and at times symptoms of scalenus anticus syndrome.[3]

The thoracic spine causes considerable discomfort about the shoulder. Pain simulating angina pectoris can be differentiated because the pain is usually superficial, bilateral and lacks the effort syndrome.

The lower dorsal spine may produce symptoms of gall bladder disease, renal colic and intercostal pain. Degenerative joint disease of the lumbar spine produces backache, symptoms of sciatica and disc pathology.

The hip is of definite significance because involvement is frequently disabling. Early degenerative changes in the hip may cause intermittent referred pain to the groin, the anteromedial aspect of the thigh and even the knee region of the affected hip. Although both hips may be involved usually one hip is more involved than the other. The patient experiences pain in weight bearing, walks with a noticeable limp, and may have a shortening of the affected extremity.[4]

The knee joint is one of the most frequently involved joints especially in the very obese patient. A constant and prominent feature of osteoarthritis of the knee is the palpable crepitation with joint motion. The crepitus is often gritty, crackling, and may be audible. The patient experiences aching pain on walking, especially up and down steps. Stiffness appears after sitting and on arising in the morning.

The third diagnostic aid is the laboratory report. Degenerative joint disease has no characteristic laboratory manifestations in contrast to other types of arthritis. The sedimentation rate as Steinbrocker [8] explains may be elevated on an "idiopathic" basis in a surprisingly high number of older people at or after menopause, probably on an unexplained metabolic basis.

X-ray findings include:

(1) Narrowing of the joint space.
(2) Condensation of bone near the articular cortex with osteophytes, spurs and lipping.

Ward [5] says that biopsy of the synovia in osteoarthitis does not show a microscopic picture characteristic of the disease itself. Such biopsy, however, is often helpful in excluding other diseases such as rheumatoid arthritis, tuberculosis and specific infectious arthritides.

SUMMARY

IN ELDERLY patients having a localized joint disease with a pattern of x-ray findings and no systemic manifestations, the total picture suggests osteoarthritis.

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Contact Dermatitis Treated with Fludrocortisone

STEROID-ANTIBIOTIC COMBINATION IN THE INFLAMMATORY DERMATOSES

In an industrial state like ours, contact dermatitis is an ever-present threat. Dr. Clayman here reports success in clearing up the itching of this dermatitis by the use of a preparation containing fludroeortisone, combined with an antibiotic.

Contact dermatitis is a common allergic condition, resulting from repeated contacts with specific chemical or biologic substances. Such substances are ubiquitous, affecting tradesmen, technical personnel, or workers in nearly all branches of industry. The chief symptom of contact dermatitis is pruritus. In the acute phase, erythema appears first, and may be followed by vesiculation and edema. Where there is continued contact with the allergen, a thickened fissured, dry dermatitis may ensue. In either case, secondary infection may be a complicating factor.

The only certain "cure" for contact dermatitis is the elimination of the offending allergen. However, local treatment is of definite value, especially to allay the itching associated with the dermatitis. For this purpose, topical steroid therapy may be employed. Fludrocortisone,[1] the 9-alpha-fluoro derivative of hydrocortisone,[2] is known to possess at least a tenfold greater anti-inflammatory activity than its parent compound.[3] The combination of fludrocortisone with certain antibiotics may provide the additional advantage of preventing or controlling many secondary pyogenic infections associated with the dermatitis.[5] Although side effects with topical fludrocortisone therapy,[4] including sodium retention and hypervolemia, have been reported,[5] these effects are rare in normal use of the drug.[6]

In evaluating the clinical efficacy of the fludrocortisone-antibiotic combination, I am reporting on 36 patients with contact dermatitis. The results in 24 additional patients with miscellaneous inflammatory dermatoses, receiving the drugs are also included.

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MATERIALS AND METHODS*

Both ointment and lotion contained fludrocortisone acetate, 0.1 per cent; neomycin sulfate, 0.25 per cent; and gramicidin, 0.25 per cent.

The ointment was formulated in a plasticized hydrocarbon gel base; the lotion in an oil-in-water, emulsion-type vehicle.

All patients were advised to apply the lotion or ointment as thinly as possible, without rubbing it into the skin. The medications were applied as often as necessary to relieve itching, but only to localized areas. At times, the lotion and ointment were used in conjunction with other shake lotions or pastes, respectively.

CLINICAL RESULTS (With Particular Reference to Relief of Pruritus)

Condition	Number of Cases	Marked Improvement	Satisfactory Improvement	No Improvement
Contact dermatitis	30	22	8	0
Rhus dermatitis	6	6	0	0
Seborrheic dermatitis†	5	3	2	0
Lichen simplex chronicus	4	2	2	0
Nummular eczema	3	3	0	0
Infectious eczematoid dermatitis	2	1	1	0
Infantile eczema	1	0	1	0
Atopic dermatitis	3	3	0	0
Intertrigo	2	2	0	0
Pityriasis rosea†	2	0	1	1
Prurigo	1	1	0	0
Psoriasis†	1	1	0	0
TOTAL	60	44	15	1

†Medication was used in these instances primarily for the relief of itching.

OBSERVATIONS

The majority of patients suffered from contact dermatitis, including 6 patients with Rhus dermatitis. In these cases, we found fludrocortisone to be of immeasurable assistance in overcoming the acute phase of the dermatitis, including both the pruritus and the underlying dermatological condition. The results shown in the table are indicative of these effects. In 28 of 36 patients with contact dermatitis, improvement was obtained rapidly, and in the remaining 8 patients, the effect was satisfactory. Of the 24 patients with various inflammatory skin conditions, 17 showed marked and prompt improvement, and 7 exhibited satisfactory results. In only one case (pityriasis rosea) was no relief of itching obtained.

In two instances (nummular eczema and contact dermatitis), patients reported a peculiar irritating effect on first application of the ointment. However, this did not persist with continued use of the drug, and both patients were subsequently relieved of pruritus, and showed definite improvement of the dermatitis. There were no other adverse reactions to either lotion or ointment.

SUMMARY

1. Sixty patients with various inflammatory dermatoses were treated with lotion or ointment containing 0.1 per cent fludrocortisone combined with neomycin and gramicidin.

2. Of the thirty-six patients with contact dermatitis, all showed marked to satisfactory improvement, especially of the pruritus.

3. Twenty-three of 24 patients with other inflammatory dermatoses responded to treatment in a similar manner. One patient (pityriasis rosea) did not have relief of itching.

4. Transient local irritation was observed in two cases. It was not necessary, however, to discontinue therapy. There was no evidence of percutaneous absorption of the steroid.

5. From our experience, we regard 0.1 per cent Florinef-S®, in lotion or ointment form, as among the most effective medications available for the treatment of contact dermatitis and other inflammatory dermatoses, especially for the relief of pruritus.

*This study was aided by a grant from The Squibb Institute for Medical Research, New Brunswick, New Jersey. The lotion and ointment are marketed under the trademark, "Florinef-S."

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Passaic

The Hyperventilation Syndrome

Anxious patients sometimes overbreath and thus produce distressing symptoms which aggravate anxiety. Dr. Goldstein here points out how this anxiety may be allayed and the patient reassured.

Although the symptom patterns of the hyperventilation syndrome have been discussed in medical publications for many years, recent descriptions in general practice journals have been sparse. As a result, practitioners have not been recognizing it, although it is common, often readily recognizable, and sometimes easily alleviated. This paper has been written both to describe the syndrome as it commonly occurs and to call attention to three phases of it which have not been adequately emphasized: (1) chest pain, (2) the strange distribution of parasthesias, and (3) abrupt onset of headache.

MECHANISM

To produce the symptoms of the hyperventilation syndrome there must be some form of forced or increased respiration. This occurs most often in sighing. The patient may not realize that he is sighing. At other times the patient may try voluntary control of respiration, generally because he notes some discomfort associated with breathing, and hyperpnea may result. Thus, he may try to control his breathing because of "pleurisy," gall bladder disease, distention of an abdominal viscus due to pocketing of gas, or pressure against the diaphragm associated with such distention. The hyperventilation may continue even when the initial stimulus producing the overbreathing is removed. This is largely due to an increased sensitivity of the respiratory center cells to carbon dioxide.[1] In each case in which the symptoms become even moderately serious, anxiety plays a large part, either in initiating or prolonging the forced respiration. Because of this, chronicity and recurrence are common, and the hyperventilator is a frequent visitor to the doctor's office.[2]

As a result of forced respiration there is an almost immediate fall in alveolar carbon dioxide content with a resulting rapid drop in blood carbon dioxide content. A respiratory alkalosis is thus produced.

The symptoms grouped roughly according to importance, frequency, or both are:

1. *Some form of overbreathing.* This is the basic incitant for the other symptoms. The patient may be unaware that he is breathing in any way other than normal. He may, however, be sighing, or he might have a feeling of suffocation. Sighing and subjective breathlessness would be expected as a result of emotional difficulties and are the usual fore-runners of the symptoms. They occur most commonly at rest,

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2. Lewis, B. I.: Journal of the American Medical Association, 155:1204 (July 31) 1954

and particularly when lying down at night. They are less likely to occur when the patient is physically active, although they may be noticed while he is reading or watching television. He may be controlling his respiration because of skeletal, pleuritic, pericardial, esophageal, gastric, colonic, or other pain. In my experience the most common pain producing the voluntary control of breathing is the one associated with gastric or splenic flexure distention, and this is most often found in anxious patients with aerophagia. The usual pain with these is in the left hypochondrium, left flank, or region of the left breast. Because motion of the diaphragm is uncomfortable, the patient splints his breathing. It is not unusual with gall bladder colic, and may even accompany acute myocardial infarction or angina pectoris.

2. *Weakness, giddiness, or both.* This may be mild or of any degree up to syncope. It is described by the patient as such or as "tiredness," "a feeling as though floating in a cloud," "I can hear you and see you, but I can't move or touch you." Actual fainting is rare, unless the fright is sudden or great. This symptom has not been adequately explained but is apparently associated with the local effects of respiratory alkalosis on cerebral tissue. In the presence of low carbon dioxide tension oxygen is given up reluctantly to the body tissue, and in addition there is probably some cerebral vasoconstriction. In my experience it correlates highly with the frequently observed orthostatic hypotension noted with hyperventilation, and the associated relative cerebral anemia would be expected to contribute.

3. *Fright,* which may proceed to acute anxiety. This helps induce and prolong the overbreathing. There is always some anxiety in hyperventilators, either as a basic incitant for the sighing, or as a result of the multiplicity of strange subjective symptoms which to the patient mean the obvious presence of serious disease.

4. *Stiffness and tremor of the extremities, sometimes associated with pain.* The patient describes it as such or as a "chill without feeling cold." This is due to the accompanying alkalosis, and as such may proceed to tetany.

5. *Palpitation.* This may be induced by the alkalosis. It appears early. It increases and is increased by the accompanying anxiety. There may not always be tachycardia, however, or other objective cardiac change.

6. *Chest pain, abdominal bloating and pains, belching, and nausea.* These are all probably due to the air-swallowing and air-sucking which commonly accompanies hyperventilation, although other observers attribute the chest pain to actual intercostal muscle or cardiac muscle pain.

7. *Dryness of the mouth and dysphagia.* These are probably largely due to the drying of membranes associated with hyperventilation, but may also be due to change in sympathetic nervous system activity.

8. *Numbness and tingling, and coolness, occasional warmth of skin.* These are due to changes in calibre of peripheral blood vessels. Vasoconstriction is more common. Vasodilation occurs in occasional individuals. This may be bizarre in distribution, involving one half of the body, or one extremity, or various areas, tending to be more in the arms, legs, and head.

9. *Sudden headache.* This occurs most commonly at the back of the neck, temples or frontal area. It is my impression that it is in the region of scalp or neck muscles and is associated with the muscle spasm of alkalosis.

10. *Yawning.* This is frequently mentioned by the patient.

THE patient may not be aware of overbreathing or sighing, and it may require careful questioning or observation on the part of the physician to recognize its presence.

Any single one or combination of the above may be the presenting or only symptom. For this reason hyperventilation is often diagnosed as "effort syndrome" when chest pain is the primary complaint; "low blood pressure" when giddiness and weakness are present; "poor circulation" when numbness and tingling are the main symptoms; "epilepsy" when tetanic contractions are associated with clouding.

TREATMENT

THE hyperventilation syndrome is closely connected with anxiety. It is to this that treatment must be particularly directed. A good physician-patient relationship is necessary. The most important single thing a practitioner can do is to reassure the patient. This he must do first by establishing (to the patient's satisfaction) that he has examined adequately and excluded serious causes of these ominous-appearing symptoms. Then he must explain that the symptoms while not serious are not imaginary but are related to the hyperventilation. This is best demonstrated by having the patient breathe forcefully in the sitting-up position until symptoms are produced. In the physician's presence and with the reassurance already given, the symptoms are never as severe as originally, and it is unusual for all the patient's usual symptoms to appear, but enough are produced to convince the patient of the connection. The relationship of sighing to emotional situations then may be recalled to the patient, and in addition the relationship of aerophagia to emotional situations may be discussed.

If possible, at this point, the physician may find it desirable to allow the patient to mention relevant personal history. However, the doctor should not insist on this if the patient is reluctant. Urging may precipitate further anxiety which the practitioner may be unable to handle. Mild sedation may be prescribed. The new tranquilizers are of particular benefit.

In most patients, recurrences are common and it is an unusual individual who understands and accepts the explanation fully in one visit. Reassurance on later visits and re-explanation and redemonstrations may be necessary. With many patients, simple reassurance and sedation are of little benefit. In these psychiatric help may be useful.

In my experience, no aid is derived from the use of simple mechanical devices such as rebreathing in a paper bag, or holding a cork in the mouth; anxiety may even be increased. Rice [3] has suggested training patients out of the habit of sighing. This is difficult and by focussing attention upon the immediate symptom often aggravates it.

3. Rice, R. L.: American Journal of Medicine, 7:691 (June 1950)

SUMMARY

OVERBREATHING or sighing may result in a multiplicity of symptoms, some of which are bizarre and frightening. This occurs commonly in anxious patients and increases the anxiety. Hyperventilation may also be precipitated by painful or uncomfortable breathing accompanying organic disease. The symptoms themselves are often mistaken for more serious disease by inexperienced observers. Treatment consists primarily of allaying anxiety, often best done by reproducing the symptoms and by reassuring the patient. Patients may require psychiatric help when these simple procedures prove ineffective.

150 Boulevard

Aging Need More Light

Workers in the age group 45 to 64 need almost twice as much light as those in the 17 to 24 group. Apparently the rate of change increases sharply at approximately 45 years, according to Sylvester K. Guth, director of a research team at General Electric. Their findings indicate definite need for higher footcandle levels with increasing age, he points out. Having established a visibility level of about 7, the older group required 80 footcandles while those in the younger group attained the same level with only 50 footcandles. —*Medical Science,* Feb. 25, 1957.

Special Report • • •

Hazards of Radiation*

In May 1957 a committee was appointed at Newark Presbyterian Hospital to investigate radiation hazards. After making surveys of the literature, the committee drew up the following report, which after deliberation, was approved by the Medical Board.

The Presbyterian Hospital of Newark as far as is known, is the first hospital in New Jersey to take such action.

Fifty per cent of all radiation hazard to which the public is exposed during life, from whatever cause, is of medico-dental origin. It is, therefore, the responsibility of each member of the profession and of each hospital staff to reduce radiation hazards in every possible manner. With this in mind, the following report was prepared.

Radiation hazards are found to arise from three sources:

1. Natural radiation: cosmic ray, normal exposure to earth materials, and so forth.
2. Material derived from atomic splitting and fission testing atom bombs, exposure to waste materials, and the like.
3. Medical and dental exposure to radiation.

More than 50 per cent of the total amount of radiation the average citizen is exposed to at this time is derived from the third category, medical and dental sources, and is, therefore, controllable.

It is estimated that for every piece of equipment in the hands of trained personnel in the field of x-ray, 40 machines are being used by other than trained radiologists. A high proportion of these machines are inadequately equipped. Proper controls are lacking. Many machines are poorly designed and hazards exist both to the operators and to patients subjected to poorly controlled radiation.

To meet this problem the following recommendations are made:

1. Each unit should be regularly inspected by a qualified expert to determine its protective factors, accuracy of dosage, scattering of radiation, and so forth.

FLUOROSCOPY

2. All fluoroscopes should have as standard equipment the equivalent of 2 to 3 millimeters of aluminum filter.
3. The fluoroscope should move together with the protective screen.
4. Under no condition should the radiated field be larger than the fluoroscopic screen.
5. Output of radiation at the table top should not exceed 6 to 10 roentgens per minute.
6. The half value layer should not be less than 2½ to 3½ millimeters of aluminum.

RADIOGRAPHY

7. Each radiography unit should have, at minimum, 1 millimeter of aluminum filter.
8. The radiated field should be as small as possible, allowing coverage of only the actual area to be examined. For example, in doing chest films a cone should be utilized to limit the field to the chest only and prevent unnecessary radiation to ovaries, testes or other organs.
9. All control equipment should be in leaded booths and operators adequately protected from stray radiation.

OVER USE

10. Your committee calls attention to the excessive use of diagnostic x-ray and fluoroscopy in routine medical practice. In pediatrics, internal medicine and many other specialties, routine examination without clinical indication has become a regular procedure and in many instances has become part of periodic examinations. The committee sharply questions the scientific validity of this practice and calls attention to the cumulative exposure which must inevitably result in the course of years. Routine fluoroscopy of those under 21 is rarely justified or scientifically indicated.
11. Request for diagnostic x-rays, in hospitals and private practice, should be limited

*A Committee Report from the Presbyterian Hospital, Newark, N. J.

to truly necessary procedures. The criteria for the need of diagnostic x-ray should be sharpened and clarified. Where other diagnostic technics are available they should be utilized and relied on to a greater degree. Clinical indications for x-ray should be supplied on each request slip both in hospital and office practice.

THE AGE FACTOR

12. The age factor would appear to be important in radiation hazards. Extreme care should be used in the application of either diagnostic or therapeutic radiation of infants and young children and in women of child bearing age. Somewhat greater freedom is permissible in persons beyond 45.

FLUOROSCOPY VS. RADIOGRAPHY

13. The attention of physicians, in general, is directed toward the problem of fluoroscopy versus radiography. Whenever possible a preference should be given to radiography. The utilization of the fluoroscopic technic involves additional hazard to both operators and to patients. Roentgenologists are permitted exposure to fluoroscopy to a limited daily amount and must not be asked to perform fluoroscopy beyond the estimated limitations. Whenever possible fluoroscopy should be avoided, both in hospital practice and office practice as well.

RECORDS

14. Every effort should be made to ascertain whether previous x-rays have been made by other physicians in other clinics or hospitals. Whenever possible these reports should be made available or the film should be obtained. Every effort should be made to avoid repetition of exposure to radiation. Very clear indications should exist before repeat x-rays are requested. It is suggested, for example, that requests for repeat x-rays on duodenal ulcers just to check the healing process are, as a rule, unnecessary and frequently are unreliable.

RADIATION THERAPY

15. Patients with specific lesions, as for example, acne, warts, or rheumatoid arthritis, should be treated only after other methods of therapy have failed. Treatment should be administered by qualified experts under carefully controlled conditions. The retreatment of such benign lesions should be avoided when possible. Records should be kept of dosage and date of previous radiation and should be supplied to the therapist when application for retreatment is made.

16. X-ray treatment of an enlarged thymus gland should be carried out only in exceptional cases and not as a routine procedure. The presence of a severely hypertrophied thymus with evidence of obstructive symptoms is the usual justification for radiation of a thymus case and perhaps the only indications.

DENTAL RADIOGRAPHY

17. X-ray equipment in use by dentists is frequently defective, lacking in proper controls and safety factors. The recommendations outlined above apply here and should be carefully observed.

18. The practice of routine x-ray of teeth, without specific indications should be questioned, particularly in view of the large total amount of radiation involved and the possible gains to be derived. Routine x-ray of teeth involves a dosage of 5 roentgens compared with 0.05 roentgens for a chest film.

PHOTOFLUOROGRAPHY

The question has been raised as to the use of routine photofluorographic chest exposures on all hospital admissions and clinic patients at the Presbyterian Hospital. Your committee has given careful consideration to all factors. A review of the statistics in similar areas would tend to indicate that the number of cases with pathologic findings on routine chest films is not sufficient to warrant incorporating the practice in all routine clinic and hospital admissions. The committee would point out that the utilization of photofluorographic equipment involves about five times more exposure to radiation than with ordinary x-ray films of the chest.

Many routine admissions have had previous chest examinations in the recent past. While there are certain gains to be derived from routine procedures of this type, the disadvantages contained in the additional exposure to radiation are considerable.

19. Your committee feels that the hazards and increased expense per patient outweigh

any possible advantage and therefore do not recommend routine photofluorographic exposure of all hospital and clinic cases as has been suggested.

Exceptions may be made with certain special groups, such as food handlers, pre-employment examinations, nurses and interns. Even in this group, routine 14 by 17 chest films would make photofluorographic exposure unnecessary in most instances. An exception could be made in the older age group, Black-Stevenson patients and possibly others.

CONCLUSION

In conclusion, your committee would quote Garland[1] "It may be that the risk of not having proper x-ray examinations or treatments is greater than any possible risks to him or herself or to future generations through genetic effects, provided the examination or treatment is skillfully done with shielded beams."

It is not the purpose of this committee to discourage the proper and scientific use of diagnostic and therapeutic radiation. Scientific studies suggest that there are large margins of safety. Nevertheless, the weight of evidence indicates that it is undesirable and unwise to expose the total population to increased radiation except under adequate, carefully controlled conditions, accompanied by specific criteria as to need and justification.

1. Garland—Current Medical Digest, September 1956, page 59.

Lewis H. Loeser, M.D., Chairman
Leo H. Siegel, M.D.
John J. Flanagan, M.D.
W. James Marquis, M.D.
George P. Koeck, M.D.

Physicians Art Association

The American Physicians Art Association seeks to stimulate the interest and artistic talents of physicians. Entries from all areas of the art field are welcomed; included are various forms of oil painting, water painting, drawing, sketching, sculpturing, crafts, as well as, photography.

The purposes of the organization are:

1. The furtherance of an interest in the various fields of creative art by members of the medical profession.
2. To stimulate members of the medical profession to produce works of art and to assist them to that end.
3. To hold national or regional exhibits of paintings, photographs, *etc.*, executed by members of the medical profession.
4. To issue whatever publications or undertake whatever activities that would best further these objects.

Through this organization, physicians are urged to try their skill and display their talents by showing their handiwork and thus encouraging similar activity from other members of the profession.

We suggest the following for ways of stimulating interest:

1. Arrange for groups of physicians in each medical society to meet occasionally, for the purpose of stimulating interest in other members.
2. This art group should have shows or exhibits at the local medical meetings or at hospital staff meetings.
3. Have social get-togethers with or without small art exhibits to exchange views and ideas.
4. Invite a good artist to instruct and guide the group and discuss their problems.
5. Have the group meet at specified times to do their form of art (painting, sculpturing, *etc.*) so as to gain a different aspect of their form of art from others present.
6. Urge physicians to become members of the A.P.A.A. Dues are only $5.00 per year.
7. Gain enough interest from the physicians, so that they will submit their work of art to be displayed at the annual A.M.A., where professional judges evaluate their work.

The A.P.A.A. has a large exhibit of the art work done by physicians at every A.M.A. convention. This exhibit has encouraged many who dabble at some form of art, to devote more time to it.

This association is solely for the physicians.

Any questions or ideas may be forwarded to: William Marrocco, M.D., 445 Park Ave., Paterson 4, N. J.

Historical Article

Fred B. Rogers, M.D.*

Trenton

The Old Barracks at Trenton: Military Hospital of the Revolution

Celebration of the Bicentennial of the Old Barracks at Trenton in May, 1958 directs attention to its service as a military hospital during the Revolutionary War. The Old Barracks stands as a unique memorial to the Colonial and Revolutionary history of our country. Erected in 1758, on what are now the State Capitol grounds, this handsome U-shaped stone building has witnessed two centuries of American history. Originally built to quarter British troops during the French and Indian Wars, it was rescued from obscurity and restored by patriotic citizens at the turn of this century. In addition to its present value as an historical and architectural shrine, it houses meeting rooms, a reference library, and fine museum of *Americana*. Although there were five such military quarters erected in New Jersey prior to the Revolution, the one at Trenton alone remains today. Its important role as a military hospital during the War for Independence is particularly worthy of recall in this year's Bicentennial Celebration.

Colonial medical practice and education were rudimentary during the eighteenth century. Only two medical schools—now those at the University of Pennsylvania and Columbia University—were established before the outbreak of hostilities with Britain in 1775. Contact with military surgeons who accompanied British troops serving in the Colonial period, however, had a beneficent effect on the practitioners of that day. Stephen Wickes and other medical historians have traced this valuable contact of native doctors with their better-trained European colleagues; this association provided a subtle stimulus to improved medical education and practice in the new land. The first provincial society of medical men in this country—The Medical Society of New Jersey—was organized at New Brunswick on July 23, 1766, and headed by the Rev. Robert McKean, a clergyman-physician who served as schoolmaster at the military barracks at Perth Amboy. Drs. William Burnet, the Society's second president, and John Cochran, its third president, later became the Surgeons-General of George Washington's army.

When Colonial America decided to fight her War for Independence, she lacked practically everything to conduct a war except a *cause*. Its Medical Department's first Director-General (Surgeon-General) was Dr. Benjamin Church of Boston. He proved to be a poor choice for he was soon imprisoned for "traitorous correspondence with the enemy." His successor, Dr. John Morgan of Philadelphia, European-educated founder of the first medical school in this country, worked assiduously to organize an efficient medical corps. Quarrels and political intrigue led to his unjust dis-

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missal in 1777. A former colleague, Dr. William Shippen, Jr., of Philadelphia, was appointed by Congress to replace Morgan. Shippen served actively until his resignation under pressure in 1781. It was during the directorship of Dr. Shippen that the Barracks at Trenton assumed its important role as a military hospital.



THE OLD BARRACKS

The Trenton Barracks was used for various purposes during the Revolutionary War. In January 1776, it was filled with British prisoners of war who were later evacuated to accommodate American troops. For a short period prior to the Battle of Trenton, a detachment of Hessian soldiers (British hirelings) occupied the building. After the successful blow at Trenton, groups of American militia and regular troops were quartered there. Shortly after the Hessian defeat at Trenton, a military hospital was established in the Barracks under the direction of Dr. Bodo Otto (1711-1787), an émigré physician from Brunswick, Germany, serving in the Revolutionary cause. There were few American casualties in the surprise attack at Trenton on December 26, 1776. The Hessians, however, suffered 17 killed, 78 wounded, and over 800 captured. Among those killed was Colonel Rahl, who was courteously visited by Washington as he lay dying of wounds and who was buried in the First Presbyterian Churchyard of the town. The wounded foes were promptly paroled and hospital facilities provided them under their own surgeons. Among the Hessian casualties were several officers who came under the care of Dr. Otto. Descendants in Reading, Pennsylvania, today own a German hymnal and sword given to the doctor by these patients.

Shortly after the disastrous Battle of Long Island, where Bodo Otto served as a surgeon to Berks County, Pennsylvania, militiamen, he was selected by Dr. Shippen as one of the surgeons of the Flying Camp (mobile hospital). In February 1777, Dr. Otto was appointed Senior Physician and Surgeon of the Barracks Hospital at Trenton, serving there until January of the following year. Transfer from field to hospital duty must have been a welcome change for Otto, then in his sixty-fifth year. Dr. Benjamin Rush, also a medical officer, noted his visit with Dr. Otto in Trenton on an inspection tour of hospital installations in August 1777. In the following months the Barracks Hospital received many American casualties after the fierce Battle of Brandywine in neighboring Pennsylvania.

WHERE bullets killed one, disease killed at least ten soldiers during the Revolutionary War. Typhus, smallpox, and dysentery were major threats to life and health. The military hospitals, particularly the largest one located in the Moravian settlement at Bethlehem, Pennsylvania, did heroic service in coping with great numbers of sick and wounded—in the face of inadequate supplies and attendants.

A directive from General Washington to Dr. Shippen, written at Morristown in February 1777, ordered that all recruits be inoculated against smallpox. Mass inoculation was practiced, the soldiers often bringing their wives and children for this service. In a letter dated February 17, 1777, Dr. Shippen directed that Dr. Bodo Otto report to Brigadier General Rodney, commanding at Trenton, to inoculate Continental troops and take charge of the military hospital there. A copy of this letter and a portrait of Dr. Otto can be seen today at the Old Barracks. Dr. Otto, who served as a medical officer from 1776 to 1782, was paid just tribute by his superiors, Drs. Shippen and Cochran, for his professional skill. Dr. John Cochran of New Jersey, who replaced Shippen as Director-General of the Medical

Department in 1781, served in this capacity until the formal conclusion of hostilities two years later.

In November 1781, the Barracks at Trenton rendered further important hospital service. In that month Colonel Matthias Ogden effected the transfer of 1600 invalid and sick troops from Yorktown, Virginia, for convalescent care. The State Legislature, however, followed with a resolution that 1000 of these patients be sent to Burlington and only 600 to Trenton, since the former location offered more facilities for care. Dispatched in the Fall of 1782, these troops were the last military occupants of the Old Barracks. Shortly after the close of the war, in June 1782, arrangements were made to convert the building to private dwellings.

The United States Army was demobilized following the Battle of Yorktown. A medical staff-skeleton was retained and assigned to frontier posts and coastal garrisons. The American military surgeons, however, wiser in knowledge and experience gained in the Revolution, were now more adequately equipped to deal with vital problems of their profession, which, before the war, had been primitive indeed. A rapid review of the medical activities during the Revolutionary conflict shows that in spite of great material limitations, a medical department was provided for the fighting forces which coped with the major medical problems arising from the war. Dr. David Ramsay, physician and historian, in his early *History of the American Revolution* (1789) concluded that:

> "Surgery was one of the arts which was promoted by the war. From the want of hospitals and other aids, the medical men of America had few opportunities of perfecting themselves in this art, the thorough knowledge of which can only be acquired by practice and observation. The melancholy events of battles gave the American students an opportunity of seeing and learning more in one day than they could have acquired in years of peace."

It was such experience, gained on battlefields and in installations such as the Barracks Hospital at Trenton, that helped give direction to the medical profession of a new nation.

2200 Hamilton Avenue

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Announcements • • •

Industrial Medicine Conference

At the Convention Hall in Atlantic City, on April 22, 23, 24, the Industrial Medical Association will hold a scientific seminar. Members of the American Academy of General Practice will be allowed hour-for-hour informal PG credit for attendance at this meeting.

April 22: Papers on medical care of workers, labor's health goals, alcoholism, traumatic surgery, rehabilitation, industrial cardiology, atomic fallout, and mental health problems in industry.

April 23: Papers on convalescence, statistics, radiation, motor vehicle driving standards, small plants services, occupational dermatoses, and ethics.

April 24: Papers on upper respiratory infection, patterns of industrial health, manganese poisoning, head injuries, burns, cardiac emergencies, back pain, chest injury, and antibiotics.

For further details, write to Dr. Thomas M. Thompson, Research Department, Johnson and Johnson, New Brunswick, N. J.

Tumor Slides Available for Study and Exhibit

The New Jersey Division of the American Cancer Society announces the availability of the following sets of 2″ x 2″ Kodachrome slides depicting early malignant lesions:

Bone (61 slides)
Breast (67 slides)
Chest (19 slides)
Female genital tract (60 slides)
Gastrointestinal tract (28 slides)
Genitourinary system (24 slides)
Head and neck (118 slides)
Lymphoid dyscrasias (20 slides)
Skin (86 slides)

These may be borrowed without charge by any physician in New Jersey. Call The American Cancer Society, 9 Clinton Street, Newark, N. J. The phone is Mitchell 2-4288.

ACS Luncheon

The New Jersey chapter of the American College of Surgeons announces a luncheon 12:30 p.m., May 21, 1958 in the Vernon Room at Haddon Hall, Atlantic City.

Ticket reservations are made directly with Sherman Garrison, Jr., M.D., 108 West Commerce Street, Bridgeton, N. J.—$4.00 each. Tickets will also be on sale during the Annual Meeting of The Medical Society of New Jersey on Saturday, May 17 to noon on Tuesday, May 20. Advance reservations are suggested.

Calling Maryland Alumni

Hospitality Hour (Dutch Treat) for Alumni of the University of Maryland Medical School has been called for Tuesday, May 20, Haddon Hall, Atlantic City, 5:30 p.m.

Pediatric Courses in Philadelphia

The Children's Hospital of Philadelphia announces three graduate courses in pediatrics in cooperation with the University of Pennsylvania.

1. Starting May 26, a 5-day, full-time, intensive course in "advances in pediatrics." Tuition: $115.00.
2. June 2, 3 and 4: pediatric hematology. Tuition $75. Also available is a collection of 25 abnormal blood and bone marrow slides at $15 the set.
3. June 5 and 6: Hemolytic diseases of the newborn. Tuition $50.

For registration or more details, write to Dr. I. J. Wolman, 1740 Bainbridge Street, Philadelphia 46, Penna.

Physician Heads Chamber of Commerce

Dr. Earl Warren of Paterson has been elected president of the Greater Paterson Chamber of Commerce. This is the first time in that organization's history that a physician has been elected to that office. Dr. Warren, the radiologist to the Paterson General Hospital, is an active member of our Passaic County Medical Society and is on the Board of Directors of the Paterson Y.M.C.A.

Award for Medical Manuscript

The editors of *Modern Medical Monographs* announce an award for the best previously unpublished manuscript on any clinical subject in the field of internal medicine. Only physicians under the age of 40 may compete, and the manuscript must be submitted in duplicate no later than October 1, 1958, to Richard H. Orr, M.D., 37 East 67th St., New York 21, N. Y.

The manuscript should be not less than 115 nor more than 200 double-spaced typewritten pages, and carry no more than 40 illustrations. For further details write to Dr. Orr at the address above.

Motion Picture Review

The annual publication of *Reviews of Medical Motion Pictures* is now available on request from the Film Library of the A.M.A. This publication is prepared by the Council on Scientific Assembly, Motion Pictures and Medical Television, and contains reprints of all film reviews published in *The Journal* during 1957. Write to 535 North Dearborn Street, Chicago 10, Illinois.

Paris in the Fall

You can go on a business trip to Paris this fall (Paris, France, we mean) by attending the 3rd Congress of Allergy there during the week of October 19. For details write to Dr. Sam Feinberg, 303 East Chicago Avenue, Chicago. Registration fee is $30.

A New Multiple Sclerosis Service

One of the most effective but quietly operating services to patients, is the Multiple Sclerosis Service Organization of New Jersey. It provides free (on doctor's recommendation) such services as physical therapy, wheel chair rentals, port-lifts, crutches (on permanent loan basis) walkers, braces, and so on. This unique organization is headquartered at 115 Fourth Avenue, East Orange. The phone is ORange 7-1181. Doctors of New Jersey are invited to use this Service on behalf of their mulitple sclerosis patients.

Technology Seminar

Physicians are invited to the seventh annual demonstration seminar and lectures of the New Jersey Society of Medical Technologists at Berkeley-Carteret Hotel, Asbury Park, on April 26 and 27.

The Sunday morning sessions, beginning at 10 a.m., will include papers on diagnostic bacteriology and epidemiology of staphylococci, among others.

Graduate Courses in June

New York University offers the following graduate courses to be given during June, 1958:

Symposium on Modern Therapeutics in Internal Medicine

A full-time course, June 9 through 20. Registrations are accepted for the entire ten days or for either the first or second five-day period. Given under the direction of Professor Charles F. Wilkinson. Tuition for five days: $50.00; ten days: $100.00.

The Management of Chronic Kidney Disease

A full-time two day program, June 23 and 24. Given under the direction of Dr. Laurence G. Wesson. Tuition: $35.00.

The Management of Hypertension

A full-time, two-day program, June 25 and 26 under the direction of Dr. J. Marion Bryant. Tuition: $35.00.

For more information, or to register, write to Postgraduate Medical School, New York University, Bellevue Medical Center, New York 16, N. Y.

Pulmonary Disease Symposium

The Trudeau School of Tuberculosis and Other Pulmonary Diseases, will hold a summer session in Saranac Lake, N. Y., from June 2 to 20, 1958. This provides a unique opportunity for training in chest diseases. Conducted under the auspices of the Trudeau Foundation, supported by the Hyde Foundation, this provides outstanding instruction at the modest tuition of $100 for a three weeks' session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

Thirty of the leading teachers and investigators in the Eastern United States and Canada will be brought to Saranac Lake this June to conduct seminars in their special fields. Half of the time is devoted to tuberculosis and the other half divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

Enrollment is limited. Application should be made early. A few scholarships are available for those who qualify.

All inquiries should be addressed to the Trudeau School of Tuberculosis, Box 500, Saranac Lake, N. Y.

Martland Award Winner Announced

Dr. Henry A. Connolly, Jr., has won the annual Harrison S. Martland award competition for 1957. A resident in general practice at the Overlook Hospital in Summit, Dr. Connolly wrote on "graphic reconstruction of diseased blood vessels, as applied to Osler's Disease." This paper was presented at the annual meeting of the Essex County Anatomic and Pathologic Society held on March 27, 1958. The award includes a cash gift of $250 plus an engrossed scroll. It is a memorial to the late Harrison S. Martland.

WMA is Speaking for You!

The World Medical Association is the only world-wide non-governmental association dedicated to free enterprise in medicine.

Membership in the United States Committee of The World Medical Association will bring you the opportunity to:

- Protect and promote the freedoms essential to good medical practice
- Raise the standards of medical service and health throughout the world
- Associate with physicians from all over the world in sharing professional knowledge and understanding
- Join in a world forum for solution of problems common to medicine the world over
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Make checks payable to "The World Medical Association." Mail check to Dr. Louis H. Bauer, World Medical Association, 10 Columbus Circle, New York 19, N. Y.

Contributions are deductible for income tax purposes. Membership contributions are $10 a year. A single payment of $250 entitles you to life membership. A $100 donation makes you a patron.

American Goiter Association

The American Goiter Association announces its 1958 meeting at the St. Francis Hotel in San Francisco, June 17 to 19. The program will include three days of discussion on the physiology and diseases of the thyroid gland. Further information may be obtained from Dr. John C. McClintock, Secretary, 149½ Washington Avenue, Albany 10, N. Y.

County Society Reports • • •

Atlantic

The January meeting of the *Medical Society of Atlantic County* was held on January 10, 1958, at the Children's Seashore House. The meeting was called to order by the president, Dr. Levi Walker.

The minutes of the December meeting were approved as published in the *Bulletin*.

The Board of Censors recommended that Dr. Joseph Ackerman and Dr. Amerigo George be made Regular members by transfer from their previous county societies. The Society voted the approval of the two members. Dr. George Keates and Dr. Edward McKnight were approved for Associate membership.

Dr. Gleason introduced Mr. Robert McGrade who talked on "Overhead Expense Disability Insurance." The information concerning this type of insurance had been mailed to each member of the Society. Questions and answers followed his comments. After a considerable discussion a showing of hands revealed that only five or six members were possible purchasers.

Mr. Pat Matteo, introduced by Dr. Walker, spoke on "We Have Good Schools; Let's Keep Them." He told of the problems of the schools which include increased enrollments, lack of school facilities which are always expanding, and lack of good teachers.

Dr. Fred Erskine introduced Dr. Harry Brunt, Medical Director of the Ancora State Hospital at Hammonton. He is one of our members. His subject was "The Medical Practitioner and the Mental Hospital."

The paper was an interesting and provocative one and Dr. Kaman, Hamburger, Dinenberg and Erskine led discussion from the floor.

LEONARD S. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held Tuesday, March 11, 1958, at Bergen Pines Hospital, Paramus, was called to order by L. J. Fitzpatrick, M.D., president, at 9:08 p.m., a quorum being present. The total attendance before adjournment was 80 members.

The Chair requested Dr. H. H. Schlossman and Dr. William M. Griffin to come forward and receive their certificates and cards.

The Chair asked the following new Associate members to rise: Dr. F. A. Franklin and Dr. V. V. Sica (elected January 14); Dr. T. H. Smith, and Dr. Dorothy M. Snyder (elected February 11).

The Executive Secretary read the following names, which had been approved by the Executive Committee for election:

To Regular from Associate—Selma Mitchel, Mary Robinson Richards.

To Regular by Transfer—John F. W. King—from New Castle Co. Med. Soc. of Delaware.

To Courtesy from Regular—John F. Daly.

To Associate—Regina Kesler.

Leave of Absence—Murray Kahn.

It was moved, seconded and carried that the Secretary be instructed to cast one ballot for the election of the slate.

Two public medical forums co-sponsored by the Passaic-Herald *News* were announced for March 28 and April 16. The first on "The Conquest of Heart Disease" will be addressed by Drs. J. T. E. Flynn, R. E. Kahn, and Stewart Alexander. The second "The Conquest of Cancer" will be addressed by Dr. W. T. Knight, moderator, and Drs. S. H. Lipsett, E. J. Ryan, and W. J. Roe.

The report of the first few weeks of operation of the Emergency Medical Service is encouraging. Dr. Heller emphasized that complaints are welcomed and will be investigated immediately but insisted they be made in writing to eliminate any possibility of misinterpreting or misunderstanding the facts in each case.

The meeting was addressed by Mr. Russell J. Mannino, President of the Bergen County Pharmaceutical Association. Mr. Mannino presented a strong plea for support of Assembly Bill A-23 and its counterpart S-64.

Dr. Knight, chairman of the Nominating Committee, read the list of delegates and alternates in the Class of 1958-60 to represent the Society at the May 1958 Annual Meeting of The Medical Society of New Jersey. These names had been placed in nomination at the February meeting. They are as follows:

Delegates: Drs. Victor Blenkle, Thomas DeCecio, Frederick Dilger, Marshall Driggs, George M. Knowles, John E. McWhorter, George O. Rowohlt, Lee Solworth, Gustav G. Steneck, Robert E. Verdon, Nelson C. Walker, John R. Williams, Orlin V. Wry.

Alternates: Drs. Charles A. Bailey, Leonard Brown, Vincent H. Gillson, Francis Gilroy, R. B. Hillsman, I. D. Jukofsky, Floyd E. Keir, John J. Kristal, Thomas McKinney, Samuel B. Reich, F. Dean Roylance, Abram Weiss, C. Stuart Littwin.

Replace Charles H. C. Beakes (Deceased)—Alternate Class 1956-1958 by Dorothea D. Vann as Alternate Class 1956-1958.

Nominating Committee of M. S. of N. J.—Delegate—C. Barton Barlow; Alternate—Frederick G. Dilger.

At the conclusion of his report, Dr. Knight moved the election of the slate. After being regularly seconded, the motion was passed and the above delegates and alternates were declared elected.

The Executive Secretary announced that a supply of gummed labels bearing the telephone number of the E.M.S. and instructions on how to use it, was available at the Business Office. Any member who wishes a reasonable supply of these labels for distribution either in monthly billing or by display in his waiting room, may receive them gratis.

The Chair turned the meeting over to Dr. William J. Roe, chairman of our Scientific Program Committee. Dr. Roe introduced the panelists:

Dr. Harold Aaron of Leonia, an internist practicing in New York City. He is medical consultant to the Consumer's Union and Chairman of the National Committee on Social Security for Physicians of the Physicians' Forum.

Dr. Thomas DeCecio, one of our members.

Dr. A. W. Nelson, a long time resident of Tenafly, who has practiced in West Englewood for 31 years. Dr. Nelson is past president (1957) of the New Jersey State Dental Society.

Mr. Benjamin Kendrick, Assistant Director of Research, Life Insurance Association of America, New York City.

A lively question and answer period followed the panel presentations. During this time it was pointed out that precisely the same benefits could not be secured from private underwriters at comparable costs and that group coverage would be difficult to obtain in any form because group insurance is designed to cover employees of a single employer whereas the majority of doctors are self-employed. It was also pointed out that Social Security may be obtained today by those doctors, who wish to be included, in several ways such as incorporation by the practitioner of his own business, and acceptance of part time employment by industry, or by service in the Armed Forces.

At the conclusion of the question and answer period, Dr. Heller, in the name of the Society, thanked the panelists for their time and effort.

The meeting was adjourned at 11:32 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular meeting of the *Camden County Medical Society* was held March 4, 1958, at Cherry Hill Inn, with President Ralph S. Wright in the chair. Drs. Marie A. Kelly, Jack J. Peril and Richard M. Sproch were introduced to the Society after taking the membership oath and signing the register.

Dr. A. G. Pratt read for the second time, changes in the Constitution and By-Laws that will bring our Constitution in accord with that of The Medical Society of New Jersey.

The scientific program was introduced by Dr. Elmer L. Grimes. Dr. James Dickensheets acted as chairman for the program presented by the Cooper Hospital Staff. The following papers were presented: "Staphylococcal Pneumonia," Thomas M. Kain, Jr., M.D., Bascom S. Waugh, M.D., and by invitation, George Hare, M.D.; "Massive Hemorrhage of the Colon," Eugene H. Kain, M.D., and by invitation, Robert S. Gamon, Jr., M.D.; "Cystic Fibrosis," Ronald M. Bernardin, M.D. A lively discussion followed.

EUGENE H. KAIN, M.D.

Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake on Tuesday, February 11, 1958 with Dr. Paul K. Ayars presiding. There were 33 members present.

Dr. George P. Glenn of Vineland was unanimously elected to active membership as a transferer from the Philadelphia County Medical Society.

The following resolution was adopted by the Society:

> "*Whereas*: Mosquitoes are unusually plentiful in this area, and
>
> No effective control measures have been initiated in this county, and whereas
>
> State aid is available to all counties that have established Mosquito Extermination Commissions, therefore
>
> *Be It Resolved* that the Society recommend to the Board of Chosen Freeholders the establishment of a Cumberland County Mosquito Extermination Commission."

The guest speaker of the afternoon was Dr. Richard T. Shackleford, Assistant Professor of Surgery, Johns Hopkins School of Medicine, Chief of Department of Surgery, Veterans Administration Hospital, Perry Point, Md., who spoke on peripheral vascular disease. The talk was well received and accoladed by a round of extended applause. After the scientific program, the Society adjourned to a delectable dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Harold Gorenberg presiding the *Hudson County Medical Society* held its regular meeting at Jersey City Medical Center on Tuesday, February 4, 1958.

Reports were read from the Diabetes Committee, and Dinner-Dance Committee.

The following resolution was passed unanimously by the Society:

Whereas the individual members of the Hudson County Medical Society have a vital interest in the Blue Shield Plan of New Jersey; and

Whereas the provisions of the contract of the Blue Shield Plan of New Jersey exhibit an inequity working to the detriment of the participating physician and the patient; and which in effect nullifies the Physician Lien Law

Be It Therefore Resolved that the Hudson County Medical Society demand the following policy change be effected by the Medical-Surgical Plan of New Jersey:

In third party actions, the participating physician shall not have his fee restricted by the Blue Shield Plan of New Jersey, but shall be entitled to his usual fee.

Delegates were instructed to bring this resolution to the Annual Meeting of The Medical Society of New Jersey. The assembly directed that the Secretary notify all component societies of the passage of this resolution.

An appropriation was approved for $100 plus cost of a room to be used as headquarters for the Hudson County Delegation.

Elected to Active membership were: Dr. Alvin W. Finestone, Jersey City and Dr. Alan Godwin, Secaucus.

Guest speaker was Dr. Charles Hufnagle, Professor and Director of Experimental Surgery at Georgetown University. His subject was "Present Concepts of the Surgical Treatment of Arterial Lesions."

MATTHEW E. BOYLAN, M.D.

Reporter

Middlesex

The February 19, 1958 meeting of the *Middlesex County Medical Society* was called to order by the President, Dr. Gerard R. Gessner at the Roosevelt Hospital in Metuchen at 9:00 p.m. The minutes of the January meeting were read and accepted.

Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee, reported on the applications of new members. Applications for new membership were approved and voted as follows:

To Regular membership from two-years' Associate membership: Dr. Delbert Griffith, South Amboy; Sponsors Drs. B. Copleman, Perth Amboy and C. E. Hesseltine, South Amboy. Due to the absence of Dr. Harold W. Potter, his application was deferred until the next meeting.

The application of Dr. Bernard Beuche of Spotswood was received too late for publication in the February Bulletin, so it will be published in the March Bulletin for action at the next meeting.

Dr. Gessner spoke of some of the changes to the new Constitution and By-Laws. Some of the proposed changes were discussed. Dr. Edward Brady felt that compulsory attendance was not desirable. Some of the members felt that attendance cannot be forced. Dr. Rowland suggested that an Associate member's failure to attend at least 50 per cent of the meeting's be considered a basis for non-election to active membership.

Dr. William Rubin, Chairman of the Public Relations Committee, spoke briefly on a complaint registered by the Perth Amboy Rescue Squad which was published in the *Perth Amboy Evening News* on February 6, 1958. The Rescue Squad is sometimes unable to obtain physicians to pronounce patients dead. This appears to be a local problem and few situations of this nature can be found. The Physicians' Exchange did not know of any case where emergency medical care could not be obtained. Dr. Samuel Breslow of Perth Amboy was designated to study the problem.

Dr. Gessner stated that since the Society has increased in membership we would be entitled to another delegate and alternate to the State Society's 1958 Annual Meeting. Dr. Howard Slobodien tendered his resignation as a Delegate which was accepted with reluctance.

Dr. Sokoloff introduced the speaker of the evening, Mr. Warren Wilentz, Middlesex County Proescutor. Mr. Wilentz spoke on the problem of privileged communication as outlined by the new Supreme Court ruling.

Dr. R. G. Matflerd introduced the following resolution which was accepted by the membership:

"*Resolved* that the Middlesex County Medical Society petition the Board of Trustees of The Medical Society of New Jersey to solicit the Veterans Administration for the purpose of raising the fees for medical care to the level of the minimal medical fees for Middlesex County which are $4.00 for an office visit and $5.00 for a home visit, and

Be it further resolved that the fees for certified specialists be maintained.

Dr. Fishkoff requested permission to repeat his resolution concerning Medical-Surgical Plan payments with respect to coverage and liability cases for action to The Medical Society of New Jersey. This again, as previously, was unanimously accepted and Dr. Fishkoff was asked to present this resolution in writing to have it published in the County *Bulletin*. Permission was also given to circulate copies of this resolution to the President of each County Medical Society in New Jersey.

Dr. Matflerd also asked permission to present his resolution again to the State Medical Society at its 1958 Annual Meeting concerning the inspection of hospital records. This resolution would prevent the inspection of hospital records by unauthorized persons. This resolution will be sent to each of the County Medical Societies.

Dr. Gessner reminded the members that any resolution to be considered by the State Society at the May Annual Meeting would have to be sent in writing by March 20, 1958.

In view of the fact that the convention of The Medical Society of New Jersey will conflict with

ours, our May meeting date was set at May 14, 1958.

The meeting was adjourned at 10:45 and collation was served.

R. G. MATFLERD, M.D.

Reporter

Monmouth

Dr. John H. Gibbon was guest speaker at the regular meeting of the *Monmouth County Medical Society* on February 26, at Monmouth Memorial Hospital. Dr. Gibbon, Head of the Department of Surgery, Jefferson Medical College, and a pioneer in the development of the heart-lung machine, spoke on the "Contribution of Surgery to the Treatment of Patients with Heart Disease." The program was sponsored by the Monmouth County Heart Association.

The business meeting was under the direction of the president, Dr. Theodore Schlossbach. The following officers were elected for 1958-59: David W. McCreight, President; Lester Barnett, President-Elect; Morton F. Trippe, Secretary-Treasurer; William J. D'Elia, Assistant Secretary-Treasurer; and Donald W. Bowne, Reporter. Drs. George G. Green, Francis A. Pflum and Howard C. Pieper were elected members of the executive committee for a three-year period. Dr. John F. Stockfisch was elected to the executive committee for a one year term.

Delegates to the State Society elected for a three year term were: Drs. George J. McDonnell, Daniel F. Featherston, Morton F. Trippe, Harry R. Brindle, Paul K. Bornstein, Donald W. Bowne, Theodore Schlossbach, and Lester A. Barnett. Alternate delegates elected for the same term were: Drs. John P. Mohair, Andrew P. Dedick, Jacob Goldberg, Richard H. Demaree, Urie A. Parkhill, Leonard S. Danzig, Anthony DeSpirito, and Edward A. Schauer. Dr. Percy L. Miller was elected delegate for a two-year term. Dr. Louis F. Albright was named nominating delegate with Dr. Daniel F. Featherston as alternate.

Active membership was granted to Dr. Joseph E. Campbell of Elberon. Dr. Joseph M. O'Connor of Deal was elected to Associate membership.

DONALD W. BOWNE, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held Tuesday, February 18, 1958 at 9:00 p.m. at the Medical Society Building. Dr. Samuel C. Yachnin, the President, presided.

The following were elected to membership: Active—Drs. Louis A. Trevisan, Cedar Grove, B. Frank Wadolkowski, Lyndhurst, James J. Whitford, Clifton; Associate—Rafael A. Jacobo, Paterson and Jaime Martinez, Passaic.

Resolutions on the deaths of Dr. George K. Tweddel, Sr. and Stephen G. Holster were then read and adopted.

The following members were elected as Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey for a three-year term (1958-1959-1960):

Delegates—Julian Cohen, Harry Wolfson, John A. Ianacone, Homer H. Cherry, F. Albert Graeter, Robert Brill, Joseph F. Benjamin, Roy R. Schubert, George L. Becker, Michael L. Keller, Louis A. Zuckerman, Orlo H. Clark, A. Gerard Peters, Jerome Brawer.

Alternates—John R. Gannon, Henry R. Shinefield, Stephen M. Liana, Ralph J. Veenema, William Paris, Richard P. Battin, Frank F. Jani, Morris A. Monaloy, Sydney J. Baxt, Sanfurd G. Bluestein, Henry D. Bongiorno, Irving Chrisman, Philip M. Joffe, Elias D. Lawrence, Floyd Fortuin, Robert V. Holman, Frank R. Schell, Theodore K. Graham

Nominating Delegate—Joseph E. Mott

Nominating Alternate—Joseph R. Jehl

The President then read the proposed changes to the Constitution and By-Laws of the Society. It was voted that the proposed revisions be accepted and made a part of the Constitution and By-Laws of the Society.

ARTICLE IV

Committees

Section 2. Eliminate "Committee on adult disease control" and "Committee on tropical diseases."

Combine both Committees on venereal disease control (Paterson, Passaic and Clifton) into one: "Committee on venereal disease control." Change "Committee on crippled children" to "Committee on rehabilitation."

Section 3. Change "Committee on medical care of the indigent" to "Committee on medical care of the indigent and chronically ill."

Section 4. Eliminate "Membership committee." Add "Judicial committee and Finance committee."

The President informed the members that discussions have been held concerning the adequacy of this building, and that the Building Trustees are looking into the possibility of either building an addition in the back of the present building or purchasing property elsewhere, with a view of erecting new headquarters.

Dr. Yachnin announced the subject, speaker and meeting place for the March Meeting and urged the members to attend.

The meeting was then turned over to Dr. George L. Becker who introduced the speaker, Richard A.

Hopping, M.D., Attending Proctologist and Chief, Proctologic Services, St. Barnabas Medical Center, Newark; Chief, Clara Maass Hospital, Belleville. A question period followed.

At the conclusion of the meeting, a collation was served.

DAVID B. LEVINE, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held on February 21, 1958, at the Du Pont-Penns Grove Country Club. Mr. A. William Graham, tax consultant, introduced the speaker of the day, Mr. L. G. Kearns, of the Estate Planning Department of the Wellington Fund. Mr. Kearns discussed the problems of retirement planning for the medical profession, nation-wide and as groups and as individuals. Recent trends in legislation and administrative decisions affecting estate planning were reviewed, as were the advantages and limitations of trust funds.

Dr. Ralph S. Phillips, of Bridgeton, was also a guest of the Society.

W. L. SPROUT, M.D.

Reporter

Somerset

The Somerset County Medical Society met on Thursday, February 27, 1958, in the new Van Derveer School in Somerville. Principal speaker was Dr. Henry C. Falk, who presented a paper on "Urologic Disorders in the Gynecologic Patient." The meeting was a part of a series sponsored by the Medical Societies of Somerset, Union, Middlesex, and Hunterdon Counties, and by The Department of Health of the State of New Jersey, Also sponsoring this particular meeting were the Urologic and Gynecologic sections of the Academy of Medicine of New Jersey.

The meeting was well attended and Dr. Falk gave a scholarly and interesting disseration.

A lively discussion and question and answer period followed the presentation.

At the end of the meeting refreshments were served by The Woman's Auxiliary of The Somerset County Medical Society.

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The Somerset County Medical Society met on March 13, 1958 at the Van Derveer School in Somerville. Dr. George A. Glass, the Vice-President, presided. The speaker, Dr. Albert A. Martucci, Associate Professor of Medicine at the University of Pennsylvania, discussed the new specialty of Physical Medicine and Rehabilitation. Dr. Martucci reported many misconceptions that the physician outside of the specialty entertained regarding this field of medicine and showed many of the advantages which are offered. The talk was effectively supplemented by a fine color film which was made in some of the departments of Physical Medicine and Rehabilitation at several Philadelphia hospitals.

A short business meeting followed in which Dr. Maurice L. Hayes was admitted to Active membership.

GEORGE E. GITTENS, M.D.

Reporter

Union

Under the chairmanship of Dr. Thomas S. P. Fitch, its president, the *Union County Medical Society*, held its regular meeting on March 12, 1958, at White Laboratories, Kenilworth.

Dr. Robert F. Pierozak of Linden was elected to full membership.

Dr. E. H. Pogue, chairman of the Public Relations Committee, reported on the committee's annual dinner and conference to which representatives of weekly and daily papers serving the Union County area were invited. This dinner conference has become an annual event of great importance in improving the Society's public relations.

Dr. George L. Erdman, chairman of the Blood Bank Committee, gave a report of a survey of blood procurement in Union County. The committee's opinion was that the existing hospital facilities could be better integrated and unified to meet the blood needs of the County to the complete satisfaction of the public, and that the establishing of a county blood bank would place a needless financial burden on the taxpayer, and would not necessarily insure a greater supply of blood. Dr. Erdman's report was approved.

Dr. Jack Karel, chairman of the Civil Defense Committee, introduced two guest speakers: Mr. Fred Oleson and Dr. Jacob H. Landes.

Mr. Oleson is a physicist and radiologic defense officer of Region One which includes all the eastern United States. His subject was *Radiologic Effects of Thermo Nuclear Weapons.*

Mr. Oleson was followed by Dr. Landes who is chief medical officer of Region One. Dr. Landes spoke on *Biologic Effects of Nuclear Radiation.*

At the conclusion of the meeting a collation was served.

E. H. POGUE, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Symposium on Diseases and Surgery of the Lens. Edited by George M. Haik, M.D. Pp. 260. St. Louis, The C. V. Mosby Company, 1957. ($10.50)

This volume, the Proceedings of the Fifth Annual Session of the New Orleans Academy of Ophthalmology, includes probably everything on the subject that can have clinical interest or practical value to the practicing ophthalmologist today. A concise chapter by Cordes on the embryology of the lens and vitreous and developmental anomalies contains thirty pages, most of which are devoted to well-chosen photographs of appropriate microscopic sections. Dr. Cordes also has a chapter on types of congenital and juvenile cataract, and on surgery of congenital cataract; the illustrations again are most suitable, as they are throughout the volume.

Chandler, in the role of trouble shooter, discusses certain complications occurring before, during and after cataract surgery. And complications associated with wound healing are presented by Dunnington, and with lens-induced uveitis by Irvine. The latter discusses vitreous changes associated with cataract extraction. It is interesting to speculate how small this chapter might have been twenty-five years ago before wide-spread use of intracapsular extraction, and how much of the material in it is purely the result of this operation.

If any subject is inadequately dealt with it is the capsulotomy or "extra capsular" operation for senile cataract. Vail devotes less than a half-page to the subject, and aligns himself with those who "believe that there are few, if any, indications for a planned extracapsular extraction," stating, however, that "there are a number of excellent surgeons who believe, with good reason, that the extracapsular operation is the safest one and offers better protection against vitreous in the anterior chamber and subsequent retinal detachment."

One may reasonably conclude that in the case of cataracts which are less than mature, the surgeon must weigh the possible complications resulting from retained lens matter out of its normal position against those resulting from vitreous out of its normal position.

In a round table discussion of specific problems the "experts" are in fairly complete agreement on certain phases of the subject. But they are in just as complete disagreement on type of suture, type of iridectomy, and forceps *vs.* erisophake, binocular or monocular occlusion. The average ophthalmologist is thus justified in feeling that in certain fields his opinion is fully as good as anyone's.

A. Russell Sherman, M.D.

Practical Uses of the Office Laboratory, X-ray and Electrocardiograph. Paul Williamson, M.D. St. Louis 1957. Mosby. Pp. 323. ($10.75)

Now that everybody is re-affirming his love for the general practitioner, there is going to be (or should be) increasing use of small office laboratories by family doctors. This unpretentious but practical manual is a *vade mecum* that can be followed by a home-grown technician in a simply equipped G.P.'s office. Dr. Williamson tells you how to use a counting chamber and test urine for bromides. He tells you how to read something into and out of the simpler electrocardiograms and how to do and interpret kidney function tests. If you have a microscope and Gram stain material you can recognize the Doederlein bacillus in the vaginal content and Dr. Williamson shows you how and tells you what it means. He reviews immunologic procedures, simple x-ray technics, stool examination, office mycology, and sputum studies. With each item he talks about sources of error. Altogether one of the handiest books in any MD's library.

Victor Huberman, M.D.

Office Gastroenterology. By Albert F. R. Andresen, M.D. W. B. Saunders Co., Philadelphia, 1958. Pp. 707. ($14.00)

After 40 years of practicing and teaching gastroenterology, Dr. Andresen reaffirms his belief that allergy and focal infection are major causes of digestive disturbances. He insists on the eradication of these foci, even as pre-operative measures in gastro-intestinal surgery.

Allergy is the only factor which he has found almost invariably in ulcerative colitis. Milk is the offending allergen in 60 per cent of all digestive diseases. The reader will find extensive elimination diets in the treatment of food allergy.

Dr. Andresen is a strong advocate of total roentgen surveys, and suggests that no roentgenologist should do partial studies. He also condemns the prescribing of medication before a diagnosis is made, and cites adverse reactions caused by corticotropins and antibiotics, when not indicated. He rejects the view that hydrochloric acid produces pain in ulcer, and, in fact, attributes protective and curative effects to it.

Practically all digestive complaints are explained on the basis of retrostalsis, that is, reverse peristalsis due to distal spasm or narrowing, secondary to an organic lesion or motor dysfunction. In massive gastro-intestinal bleeding, the author does not transfuse, except in severe anoxia and air hunger; even then he limits transfusions to 150 or 200 cubic centimeters of citrated blood.

He advocates consideration of shunt procedures if esophageal varices are present, even in the absence of bleeding. And if any organic lesion is present, the author does not recommend psychotherapy.

The remainder of the book is devoted to specific organs' diseases of the digestive tract, and is replete with valuable diagnostic and therapeutic information.

ISAAC GELBER, M.D.

The Doctor, His Patient and the Illness. By Michael Balint, M.D. Pp. 355. New York 1957. International Universities Press. ($7.50)

There is no book quite like this. It is an account of a series of seminars held in Britain last year, at which general practitioners discussed with brutal frankness the problems that developed out of psychosomatic illness and out of their own relationships with their patients. The book includes numerous verbatim transcripts of discussions between the GP's and the psychiatrists. The reporting is vivid and the reader can savor the flavor of the seminar. Some difficulty is produced because of differences in British and American terminology (a theatre is an operating room for instance) and because of the differences in style of practice which have developed out of the British National Health Act. But the text cuts through these superficial differences. Any general practitioner or psychiatrist who reads this book thoughtfully will have a lot to think about, talk about and put into practice.

HERBERT BOEHM, M.D.

A Synopsis of Otorhinolaryngology. By Doctors John F. Simpson, Ian G. Robin, J. Chalmers Ballentine and Charles H. Edwards. Bristol, England, 1957. John Wright & Sons. Available through Williams & Wilkins, Baltimore, Md. Pp. 443. ($8.50)

As stated in the preface, this book is intended for quick reference, or preparation for examinations. Its economy of words makes it a happy hunting ground for those with little time in search of facts. It covers the embryology of the ear, nose and throat, together with the cranial nerves and brain as they are related to that field. The etiology, pathology, diagnosis and treatment of the diseases are in orderly arrangement. There are no unimportant details, and the methods and viewpoints are limited to the one favored by the authors. Nevertheless, with but few exceptions the material presented is consistent with modern accepted practice.

The book is only 1x5x7½ inches. The type is small but easily readable and lavish in variety so that with the tabular format, it is easy to get emphasis and quick reference. Typographical errors are few. There is a sufficient number of diagrams and line drawings to clarify the description.

The general practitioner and student will find here a complete and efficient source of basic knowledge and reference. The specialist will find it elementary.

WRIGHT MACMILLAN, M.D.

Atomic Energy in Medicine. K. E. Halnan, M.D. Pp. 149. New York 1958. Philosophical Library. ($6.00)

Intended primarily for laymen, this slim and highly readable volume gives a solid view of atomic energy in medicine. Dr. Halnan covers the ABC's of atomic physics, the nature and usefulness of isotopes, the application of radiotherapy to cancer, the problems and hazards of radiation, the usefulness of radioactive isotopes in thyroid and other diseases and the medical use of high energy accelerators. The author writes with wit, clarity and authority. Were it not for the outrageous overpricing ($6 for a book of 149 pages!) this would be a highly recommended volume for any doctor outside the field of pathology or radiology. Too elementary for these specialists, it will provide an excellent underpinning for the subject for other physicians as well as for sophisticated laymen.

HENRY A. DAVIDSON, M.D.

Drugs and the Mind. By R. S. deRopp, Ph.D. New York 1958. St. Martins Press. Pp. 312. ($4.50)

We are at the dawn of psychopharmacology—the branch of pharmacology concerned with behavior-influencing or, if you prefer, mind-influencing drugs. In somewhat theatrical, but very effective style, Dr. deRopp takes us on a tour of this strange land—the drugs new and old, synthetic and natural that affect human behavior. He discusses the thesis that psychoses (and maybe neuroses, too) are but errors in biochemistry, and opens the door to the possibility that psychiatric treatment tomorrow will move from the couch to the chemist. He is, one thinks, somewhat overenchanted by the tranquilizers. They really do not work such wonders in clinical psychiatry as Dr. deRopp suggests. He dives into the folklore, the psychology, and the pharmacology of coffee and tea, alcohol and opium, marihuana and mescaline. The book is fluent reading, and it provides a fascinating source for any doctor called on to give a public talk on pharmacopsychology.

ABRAHAM LEFF, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI April, 1958 No. 4

Protective Isolation of the Tuberculous

Conference Report, Public Health Reports, September, 1957.

Compulsory isolation of the tuberculous patient was considered at a Conference on Protective Isolation of the Tuberculous, held at Denver, Colo., January 22-23, 1957. The recalcitrant tuberculous patient and methods of dealing with him have been subjects of increasing concern recently. Attending the meeting were interested persons from many fields including officials from state and national agencies, tuberculosis control officers, tuberculosis hospital directors, private practitioners, psychiatrists, sociologists, social workers, lawyers, nurses, and health educators.

ARGUMENTS PRO

The case for compulsory hospitalization was led by Dr. Edward Kupka, Chief, Tuberculosis Control, California State Department of Public Health. These arguments were offered:

1. Tuberculosis is a communicable disease spread from person to person. Its spread can be prevented by the identification and isolation of all grossly infectious persons.

2. The civil liberties of a citizen do not include the right to endanger the health and welfare of other citizens.

3. Compulsory isolation serves as a deterrent to other individuals with tuberculosis who might otherwise fail to cooperate.

4. The truly recalcitrant patient is both physically and mentally ill and at times needs the support of official action to help take necessary precautions against infecting others. Commitment on psychiatric grounds is indicated for some of these patients.

5. The really recalcitrant patient is probably more dangerous to the public health than is the nonrecalcitrant known case. As the number of infectious tuberculous patients decreases, each recalcitrant becomes relatively more important.

6. There is a small hard core of socially irresponsible persons who, in spite of a concerted psycho-

ARGUMENTS CON

Dr. Sidney Dressler, medical director, National Jewish Hospital, Denver, led the case against compulsory hospitalization. His team set forth the following arguments:

1. Recalcitrance is not a crime and may reflect psychosocial disease in the patient or the failure of the professional staff to deal with this disorder, or both. Some of these problems result from improper handling by health officials.

2. Recalcitrance is usually preventable by proper medical, social, and psychiatric care.

3. Recalcitrants represent such a small fraction of the potential source of infection that the expenditure of time, effort, and money necessary for isolating them is not justified.

4. Enforced isolation as a rule does not make recalcitrant patients cooperative and, in fact, may drive tuberculosis underground and tend to create more recalcitrants.

5. There are adequate alternatives to enforced isolation.

6. Tuberculosis is only mildly contagious.

7. There is no evidence to show that compulsory isolation has succeeded in preventing additional cases or that incarceration has favorably influenced the infection rates in a community.

social attack, will expose their fellow men to infection unless restrained.

7. Basically democratic administration of isolation laws, like all laws, is a fair general assumption in the United States today.

8. Alternatives consist mainly in preventive measures which are too costly to be practical.

9. The program has worked well in those states with both a good overall tuberculosis control program and good facilities for compulsory isolation.

8. Since many of the patients who would be prosecuted are unable to defend themselves, such laws could easily lead to abuse by authorities. Civil liberties may be unnecessarily lost or curtailed.

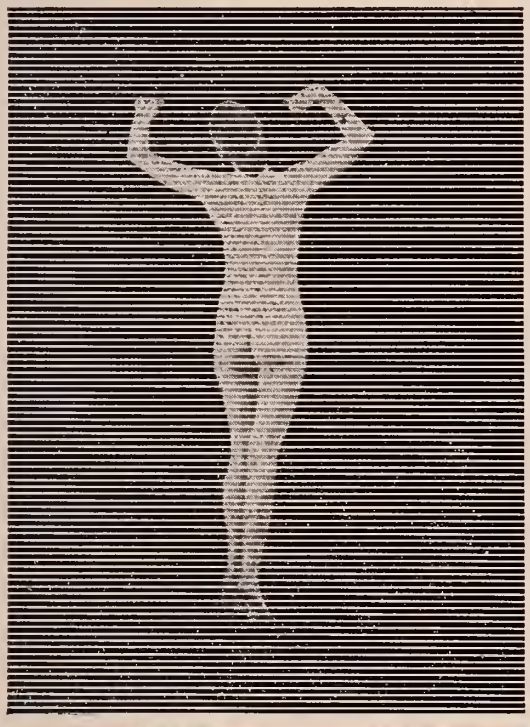
9. Tuberculosis control officials have ample tools for protecting the environment from the recalcitrant. The unknown tuberculosis cases are the main hazard. The institution of forcible hospitalization would add no more to tuberculosis control than would more vigorous application of those methods now in use.

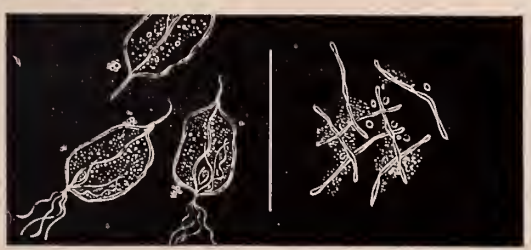
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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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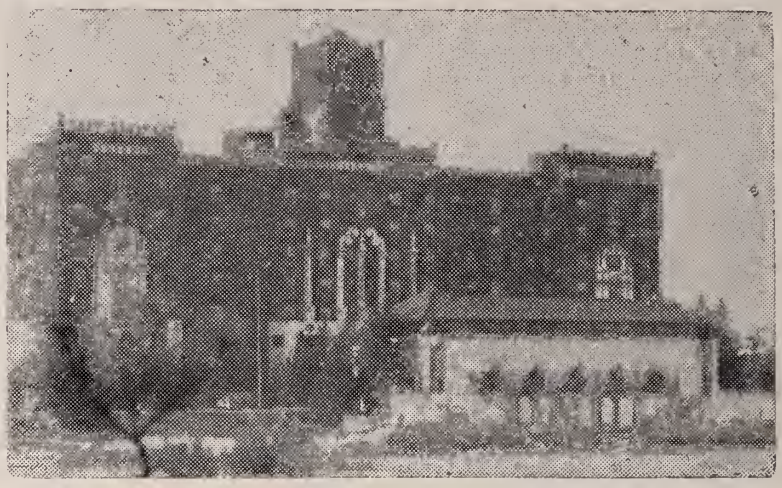
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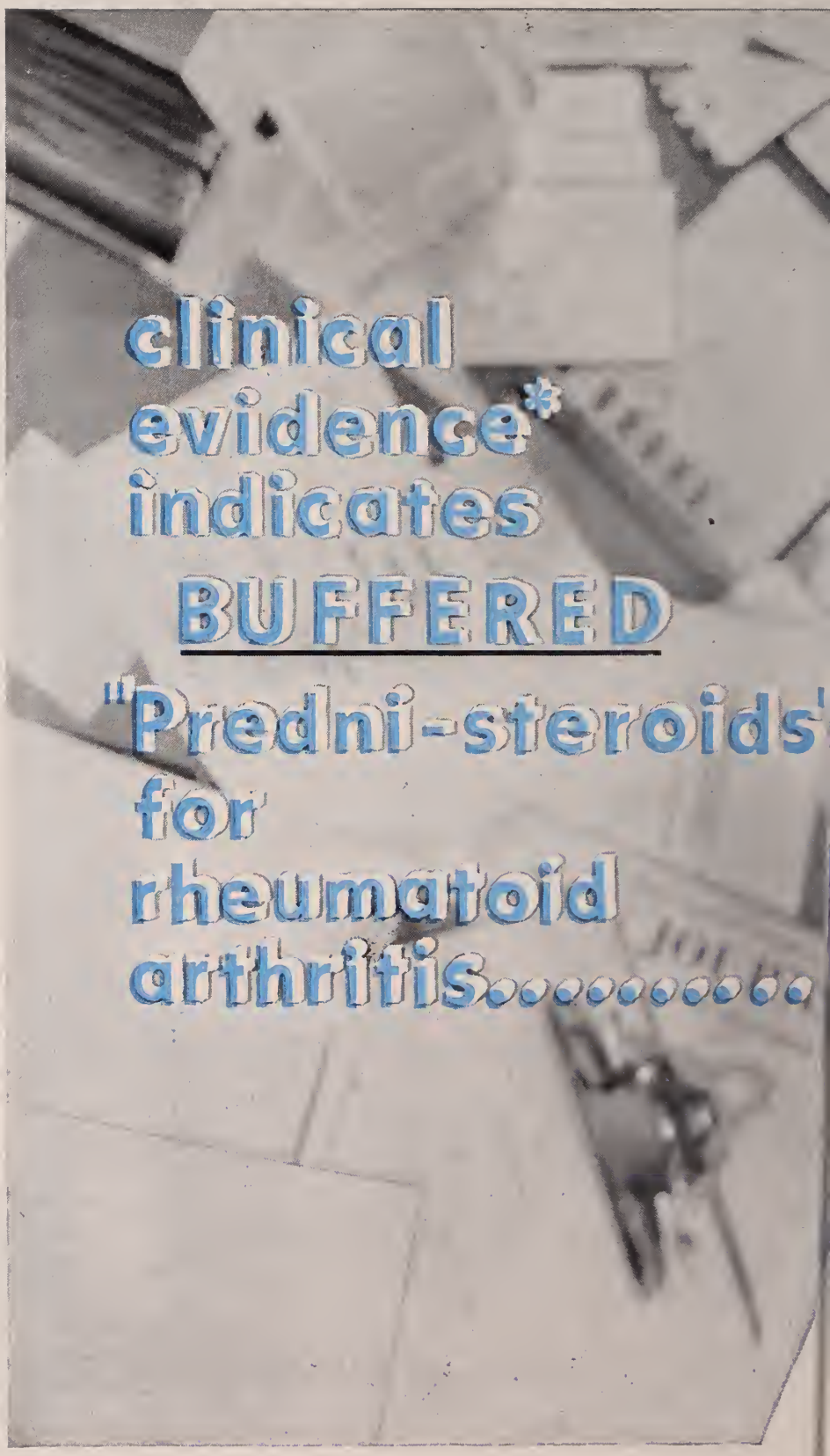
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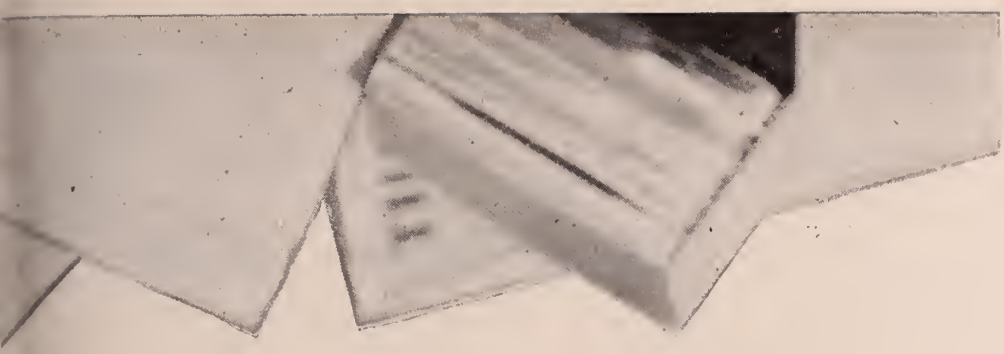
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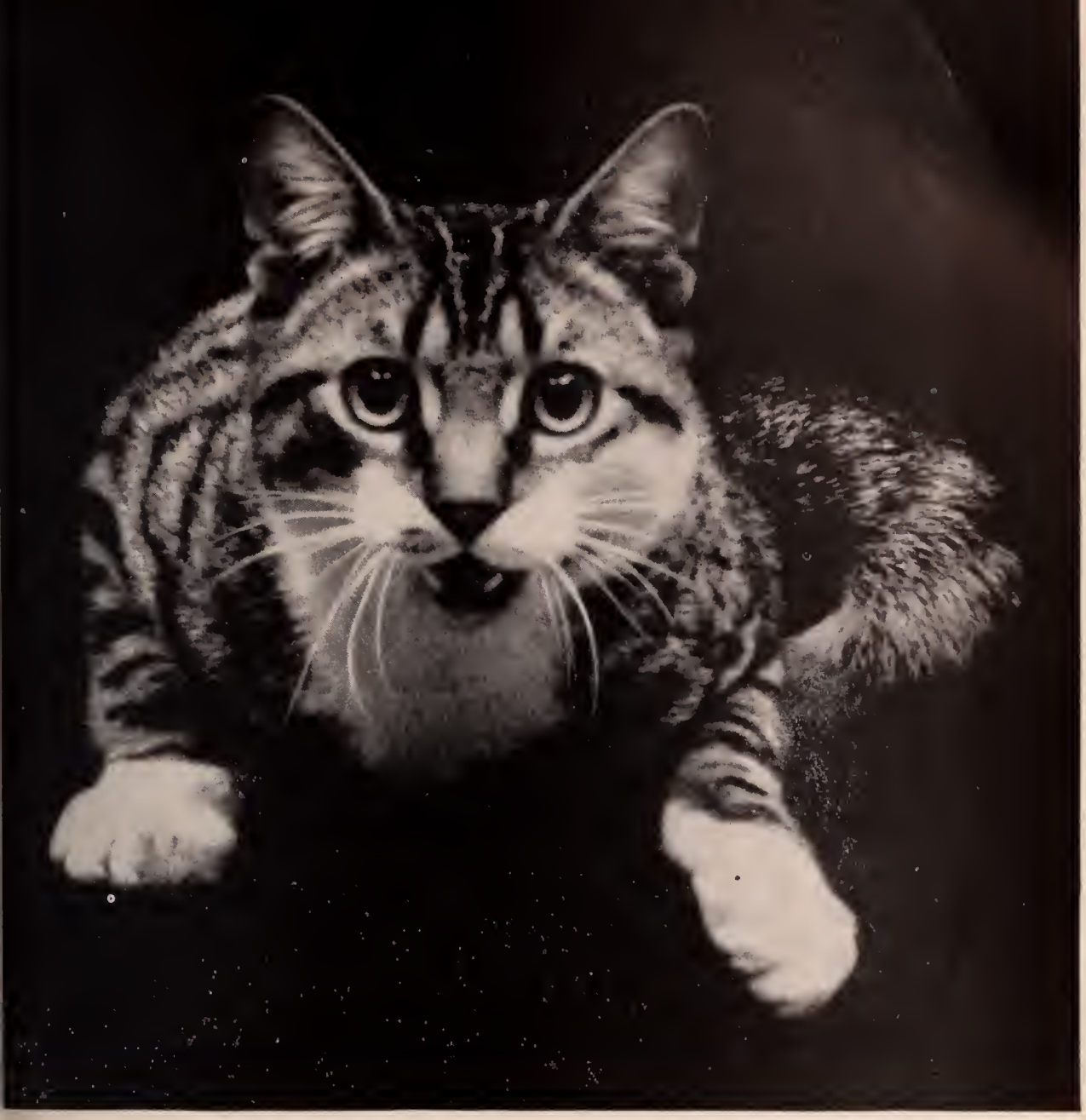
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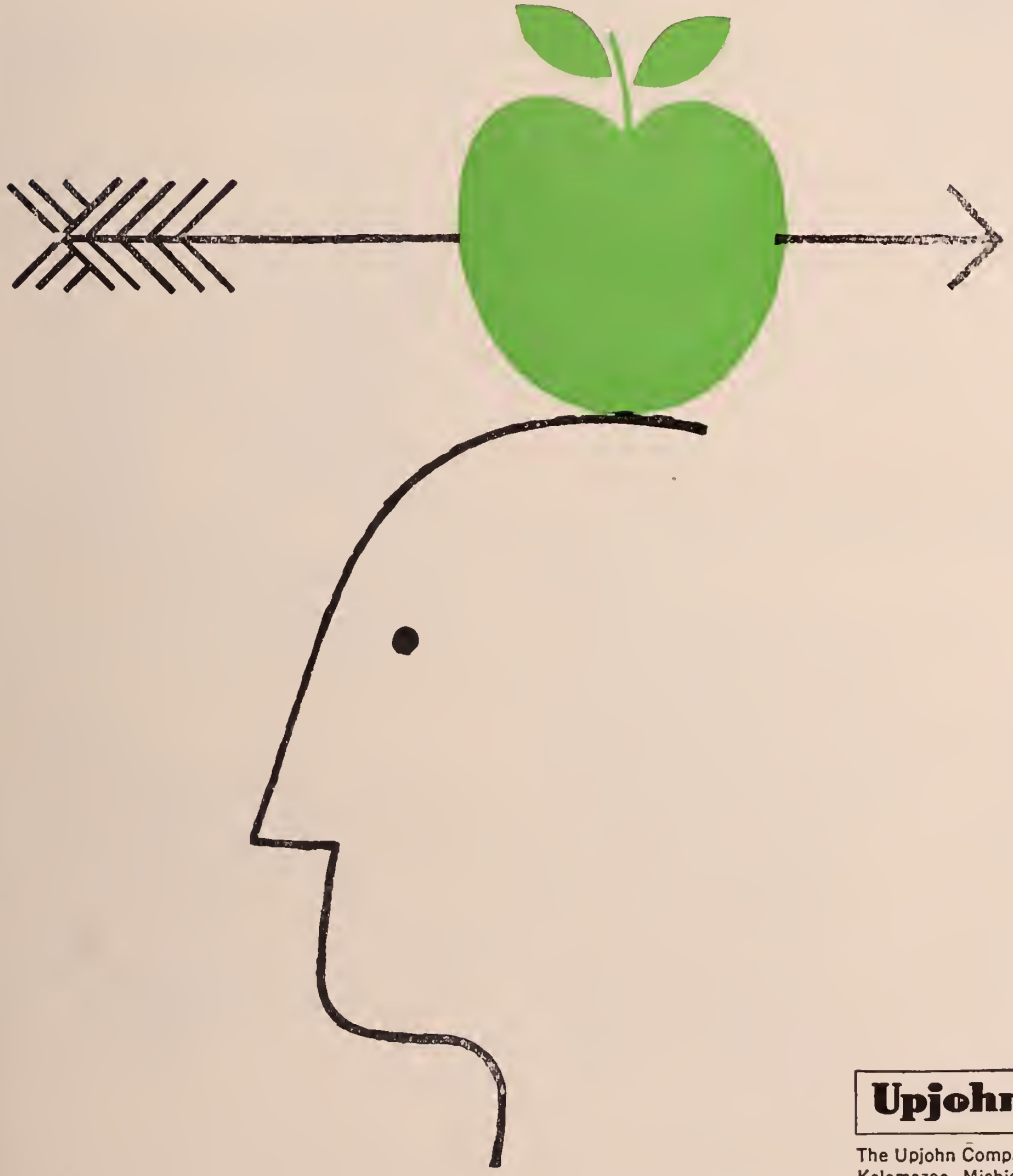
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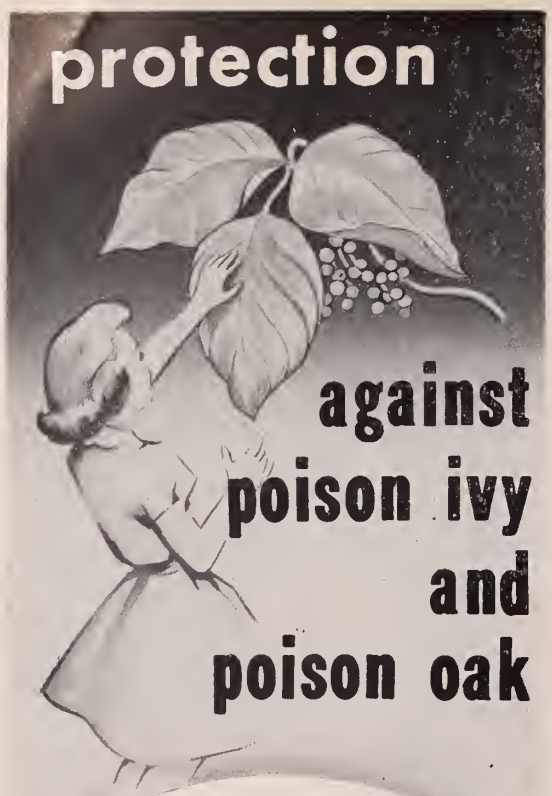
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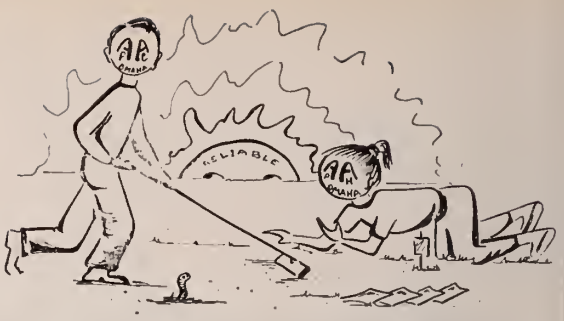
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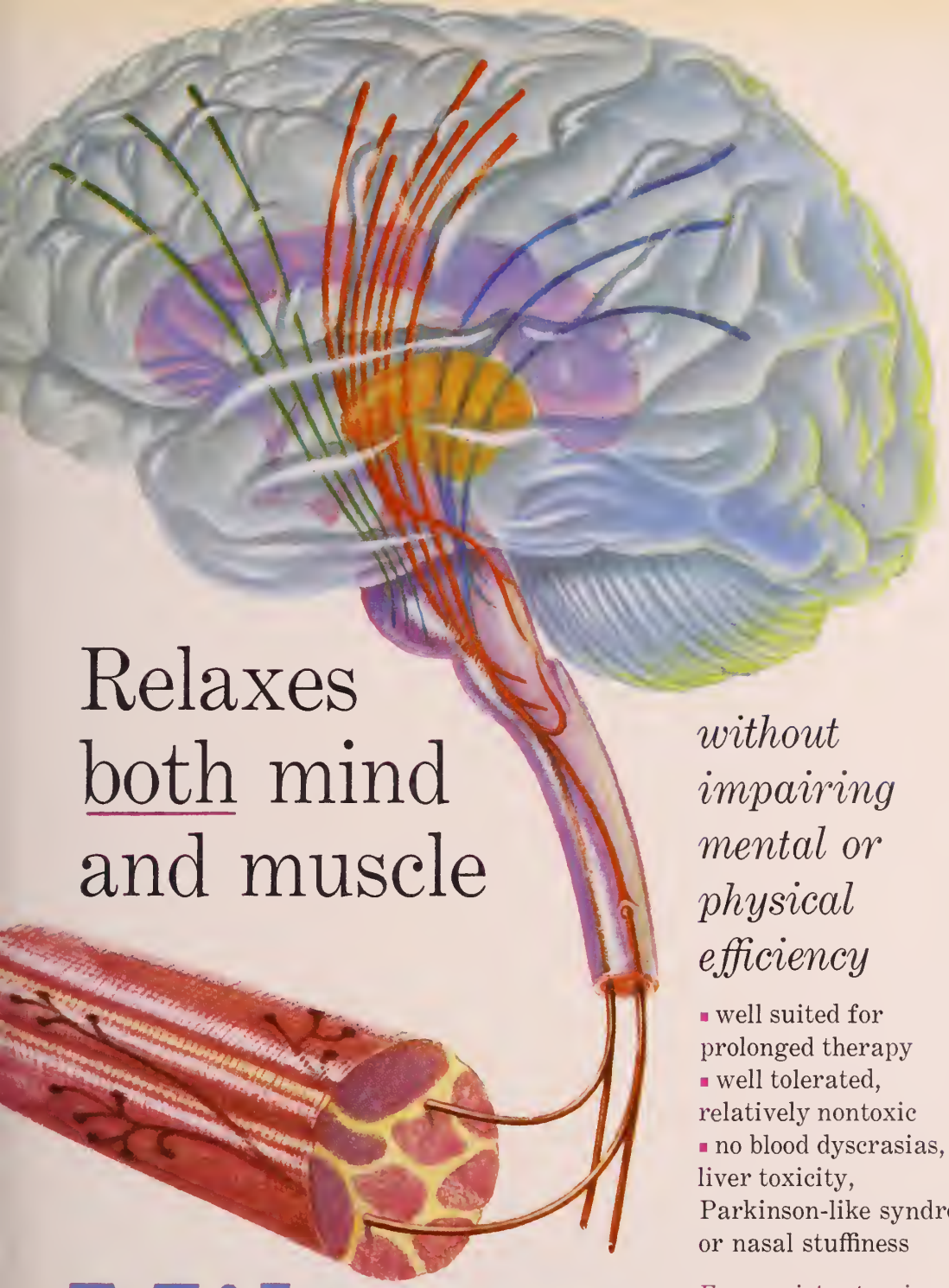
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metaphosphate produced markedly higher blood levels than capsules containing either the corresponding base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium phate, foun[illegible]

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

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de
of so[illegible]ate were published simultaneously with the last mentioned report of Welch et al.[7] These data were based on thoroughly controlled studies both in rats[8] and in man[9] and include additional findings that serve to explain, fairly conclusively, the various discrepancies that have been mentioned.

The experiments in rats[8] were carried out to study the effects of citric acid, dicalcium phosphate, sodium metaphosphate, food, oil and sorbitol on the serum antibacterial activity produced by the administration of tetracycline hydrochloride or tetracycline base. Citric acid administered in equal weight with tetracycline hydrochloride gave the highest concentrations of all the preparations studied. No enhancing effect was obtained from citric acid when given with tetracycline base. Dicalcium phosphate and food resu in lower, and sodium metaphosphate in higher, se antibacterial activity than was observed in their sence. Oil and sorbitol did not interfere with te cycline absorption.

Dicalcium phosphate is widely used as a fille various capsules, including those of the tetracycl The authors cite a large number of other studies implicate the presence of calcium ions as the caus the reduced absorption of tetracyclines and show citric acid can partially neutralize this effect. depressing effect of food on the serum levels of te cycline is likewise explained by the goodly amoun minerals contained in commercial laboratory d and they postulate that the multivalent cations be responsible for the poorer absorption of the d The authors could not explain the failure of c acid to enhance serum concentrations when adi istered with tetracycline base in contrast to its ma effect when given as the hydrochloride. Howe they hypothesized that the ability of citric acid enhance serum levels of tetra[illegible]cline is rel[illegible] ability to form complexes [illegible] unavailable for

[illegible]endum to the last mentioned paper [illegible]h et al.[7] indicates that in their study the caps of tetracycline hydrochloride, chlortetracycline hy chloride and tetracycline phosphate complex all c tained dicalcium phosphate as a filler, whereas capsules containing citric acid and sodium hexam phosphate did not contain any dicalcium phosph This could clearly explain the discrepancies note that study. Likewise, the inconsistencies in o studies may very well have been due to the prese of calcium as fillers in some of the capsules and in others.

This, however, fails to explain the most recent f ings of Welch and Wright,[10] who compared the sorption of three capsules, each containing 250 mg oxytetracycline hydrochloride — one without any juvant, one with 250 mg. of citric acid and the t with 380 mg. of sodium hexametaphosphate; no o filler was contained in any of these capsules. In t

Editorial.
The New England Journal of Medicine.
258:97-99, (January 9, 1958)

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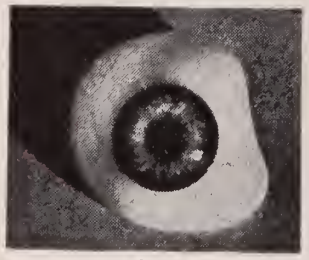


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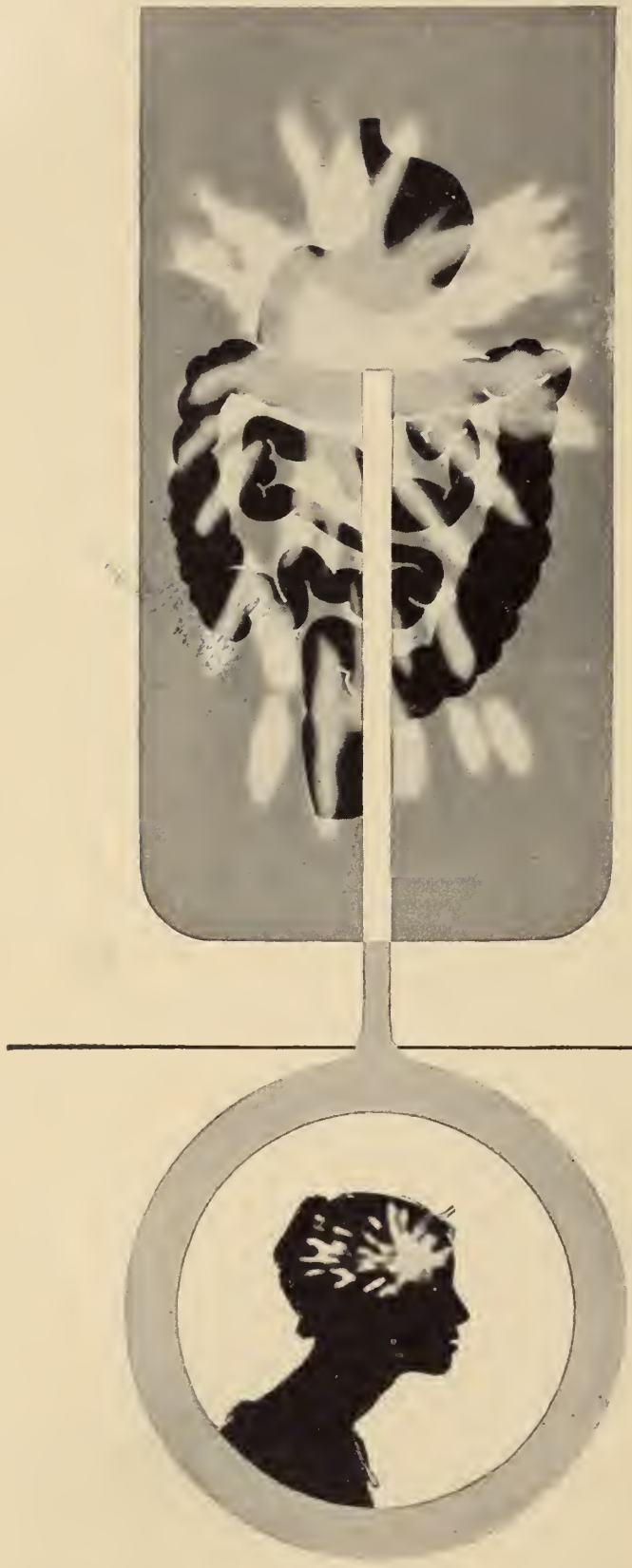
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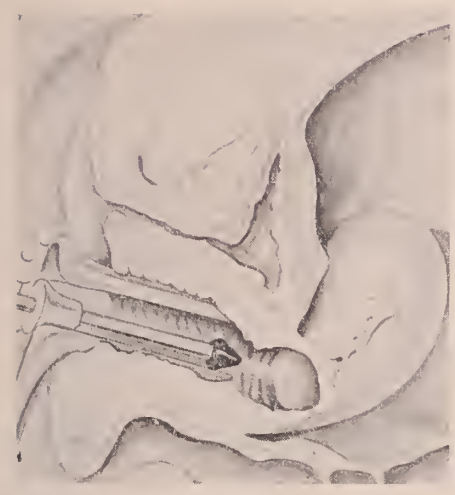


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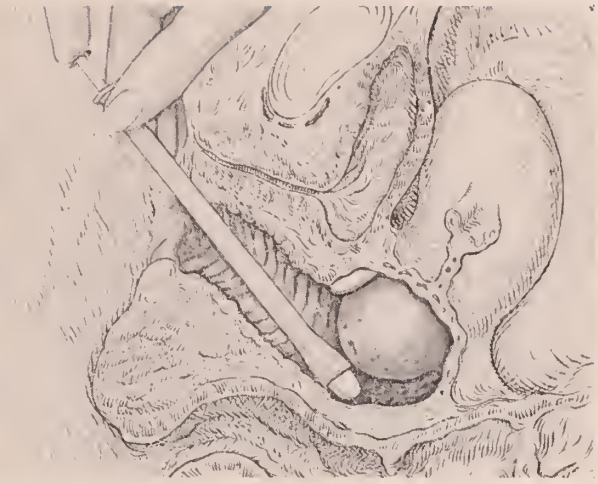
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*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

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1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
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6	13	22	4	7	5	768

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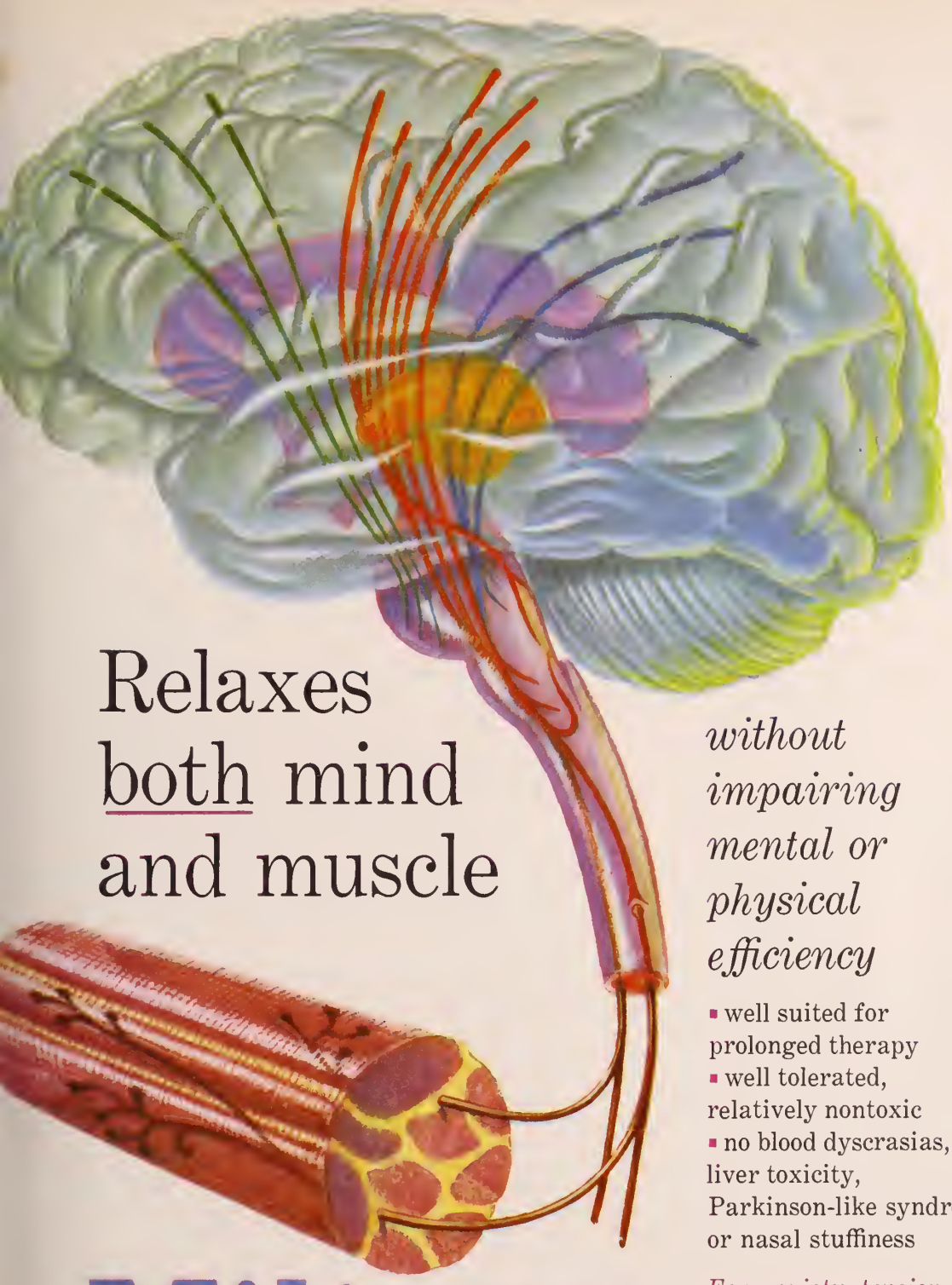
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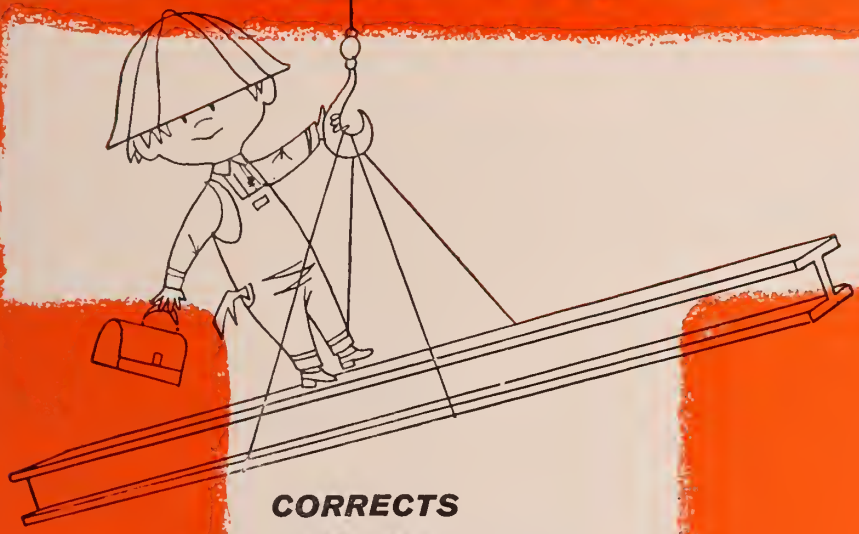
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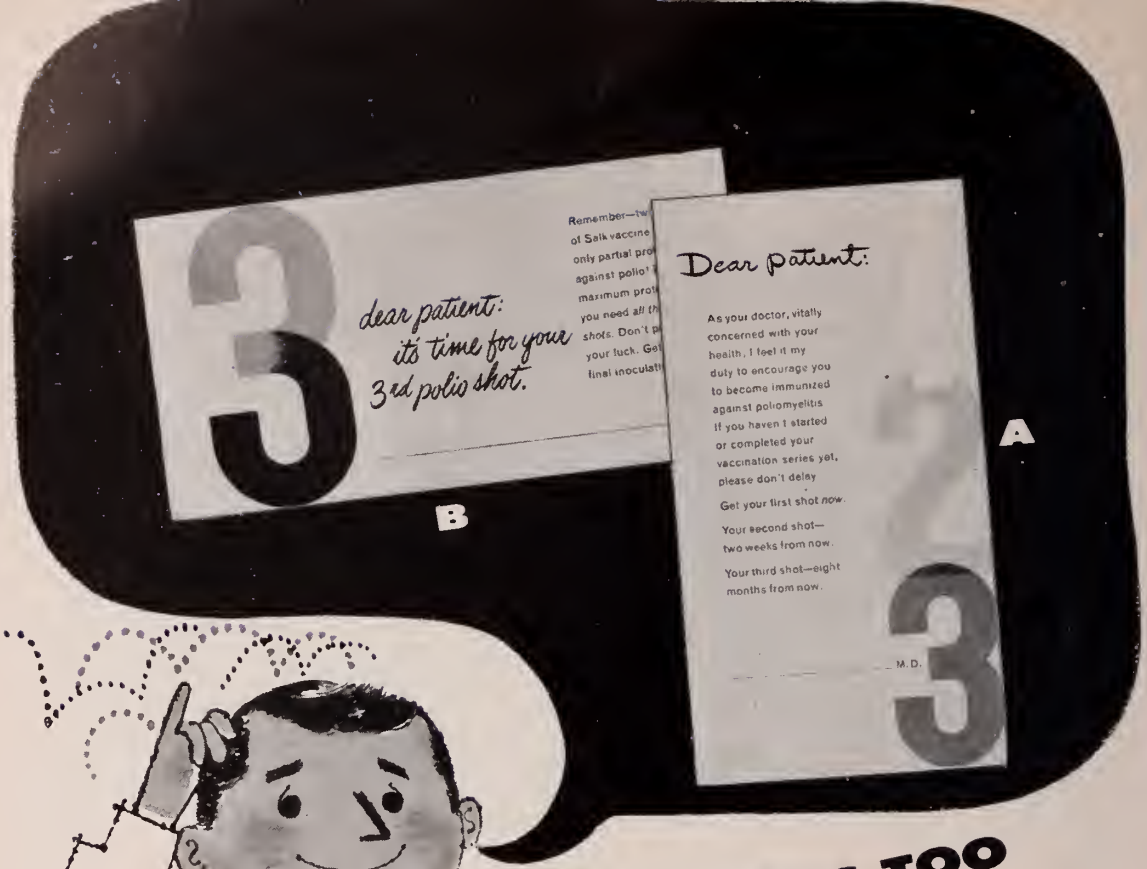
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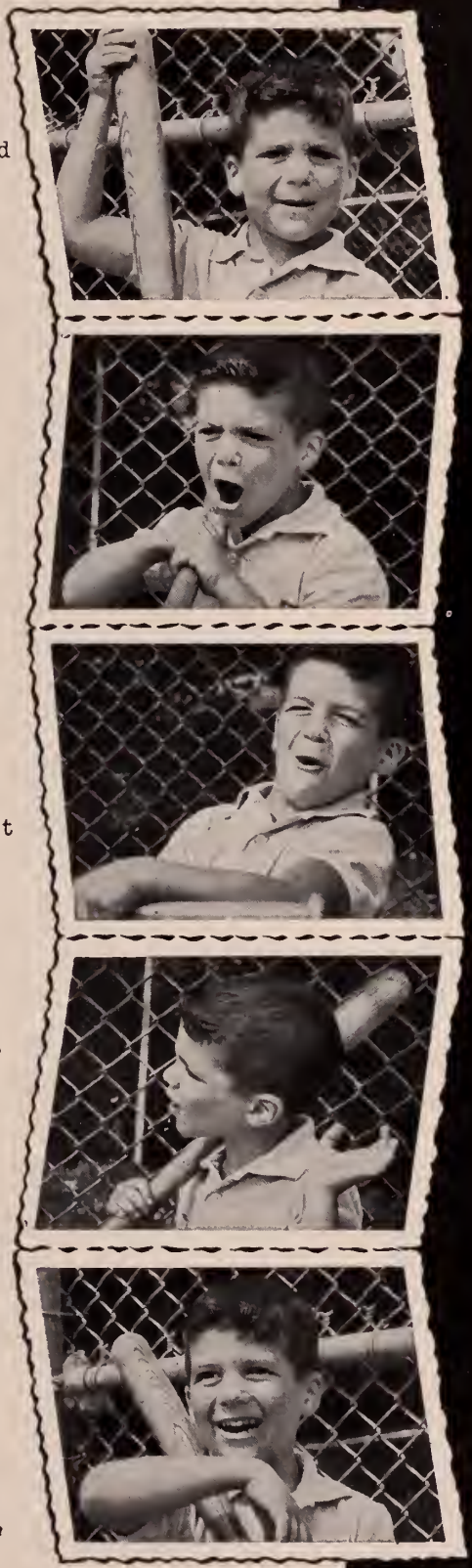
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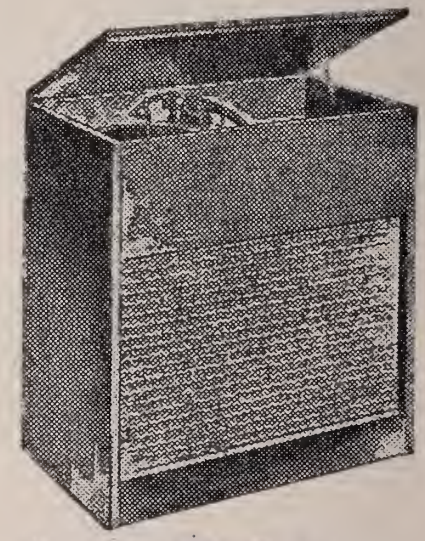
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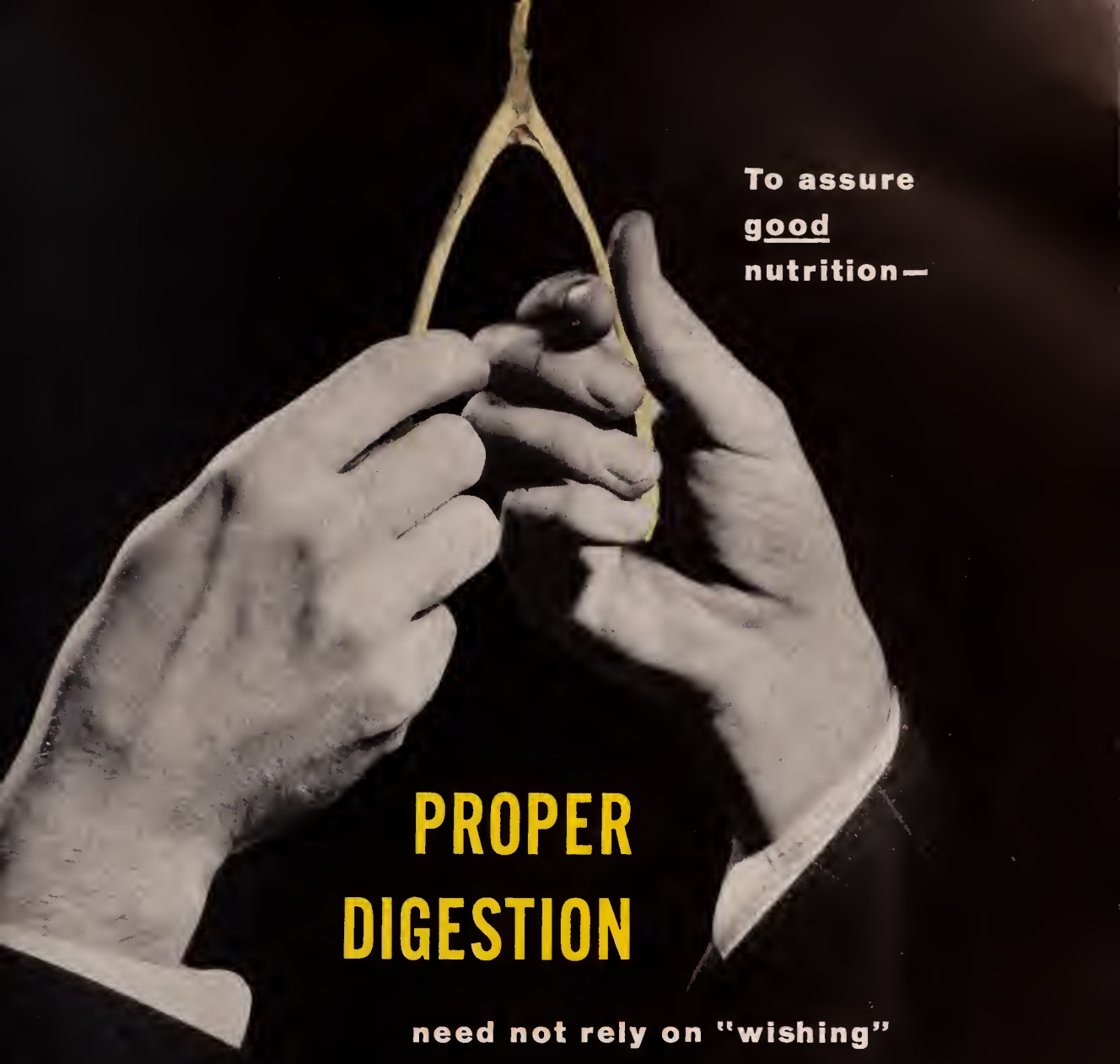


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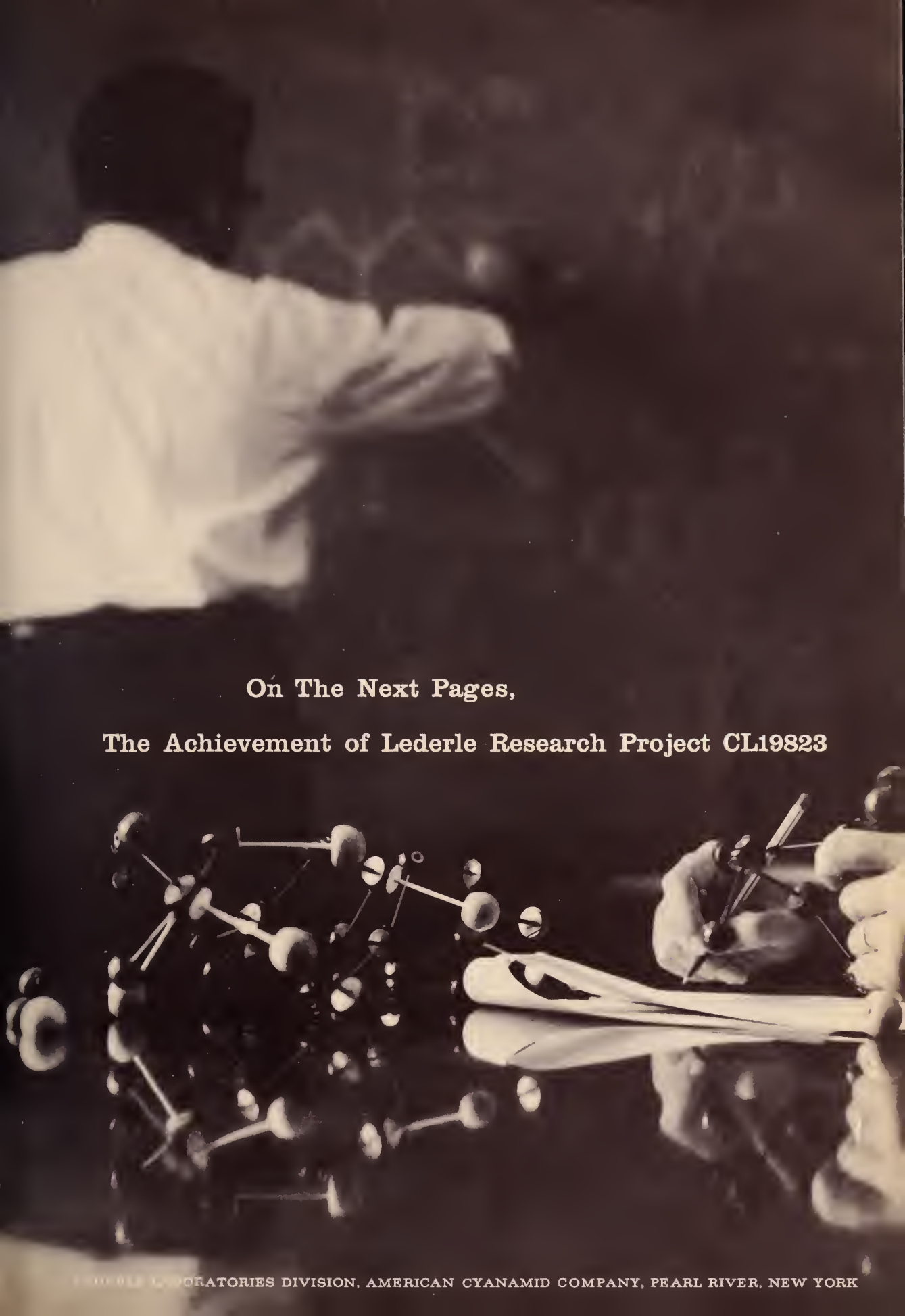
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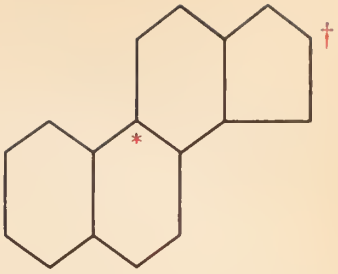
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- No potassium loss
- No interference with psychic equilibrium
- Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension-Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Schwartz, E.: Personal Communication. 4. Spies, T. D.: Personal Communication. 5. Barach, A. L.: Personal Communication. 6. Segal, M. S.: Personal Communication.

Lederle

The Promise of Aristocort

in Nephrotic Syndrome

◊ *Fourteen patients with the nephrotic syndrome have been treated with* ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

◊ *Eleven patients with pulmonary emphysema and/or fibrosis were treated with* ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

◊ *Forty-four children and adults have been given* ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Presented at Nephrosis Conf., Bethesda, Md., Oct. 26, 1957. 2. Ibid: Personal Communication. 3. Barach, A. L: Personal Communication. 4. Segal, M. S.: Personal Communication. 5. Cooke, R. A.: Personal Communication. 6. Farber, S.: Personal Communication. 7. Hellman, L., Diamond, H. D., Ellison, R., Jaslowitz, B., Murphy, M. L., Tan, C. and Zumoff, B.: Personal Communication.

Lederle

The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

Bibliography

1. Rein, C. R., Fleischmajer, R., and Rosenthal, A.: J.A.M.A., *165*:1821, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Shelley, W. B., and Pillsbury, D. M.: Personal Communication. 4. Hollander, J. L.: Discussion of Paper by Black, R. L., presented at International Congress on Rheumatic Diseases, Toronto, June 28, 1957.

in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Dubois, E. L.: Personal Communication. 2. Freyberg, R. H.: Personal Communication. 3. Hartung, E. F.: Personal Communication. 4. Hollander, J. L.: Personal Communication. 5. Spies, T. D.: Personal Communication. 6. Segal, M. S.: Personal Communication.

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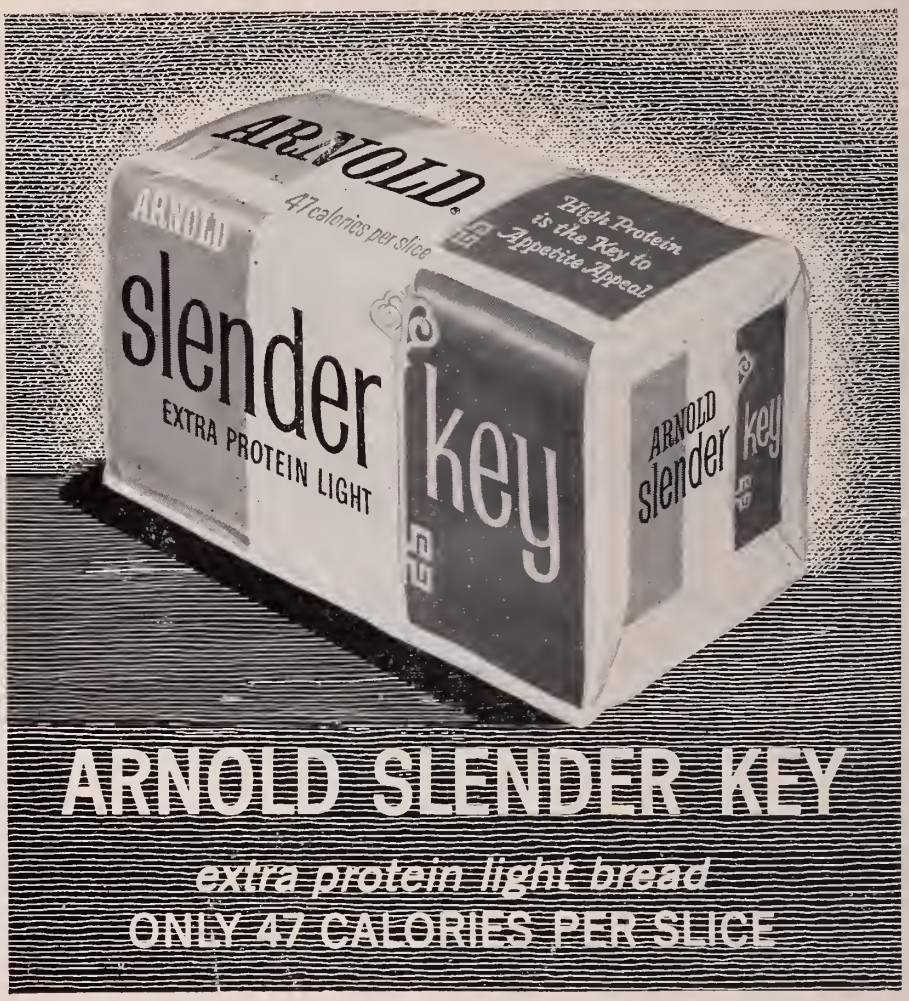
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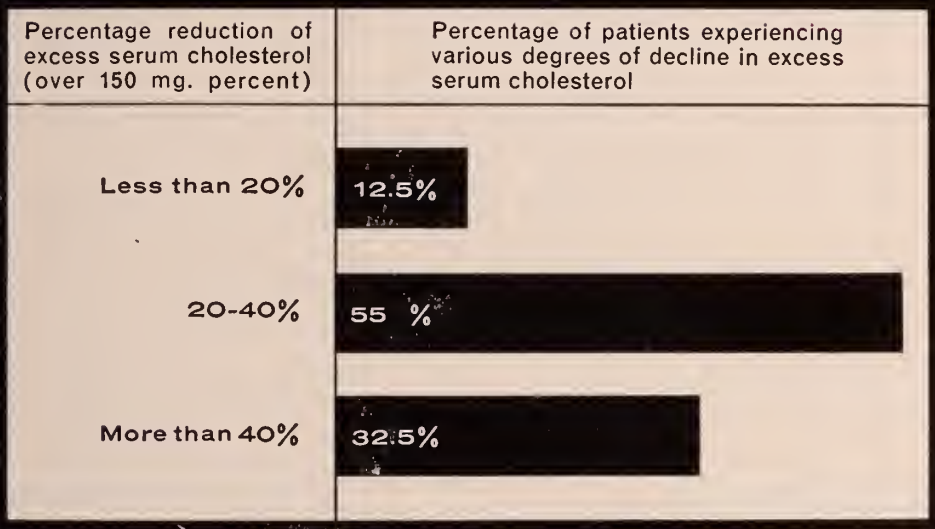
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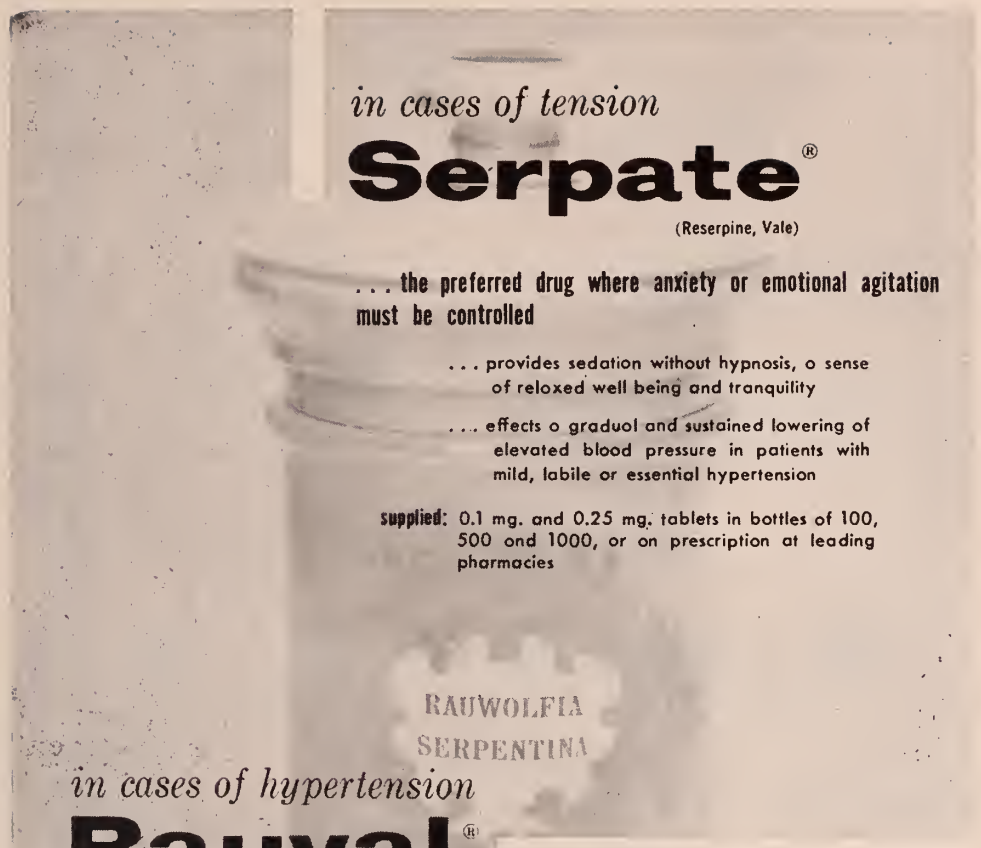
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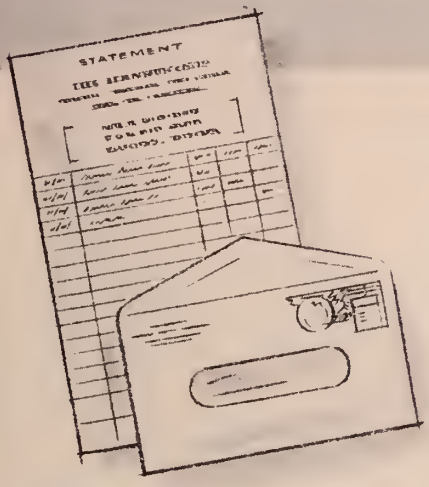
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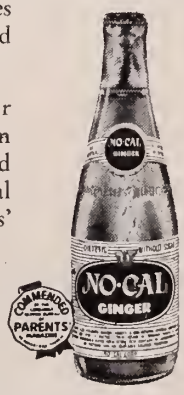


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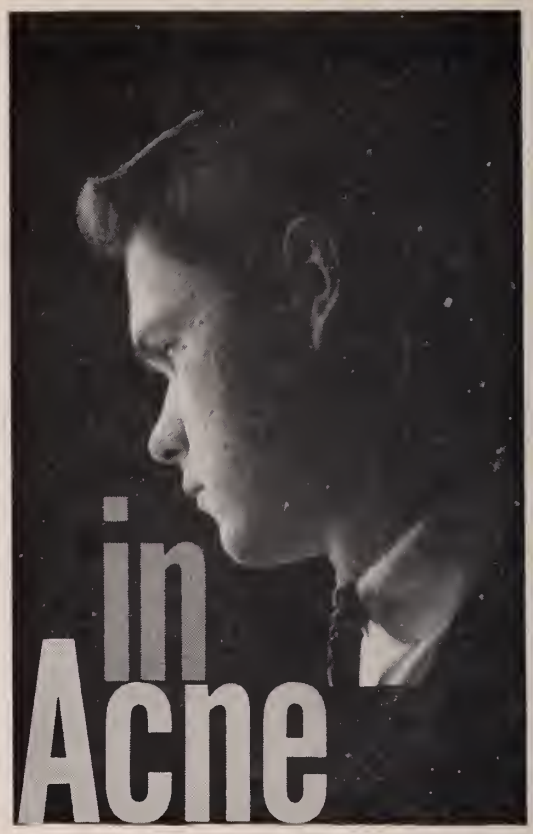
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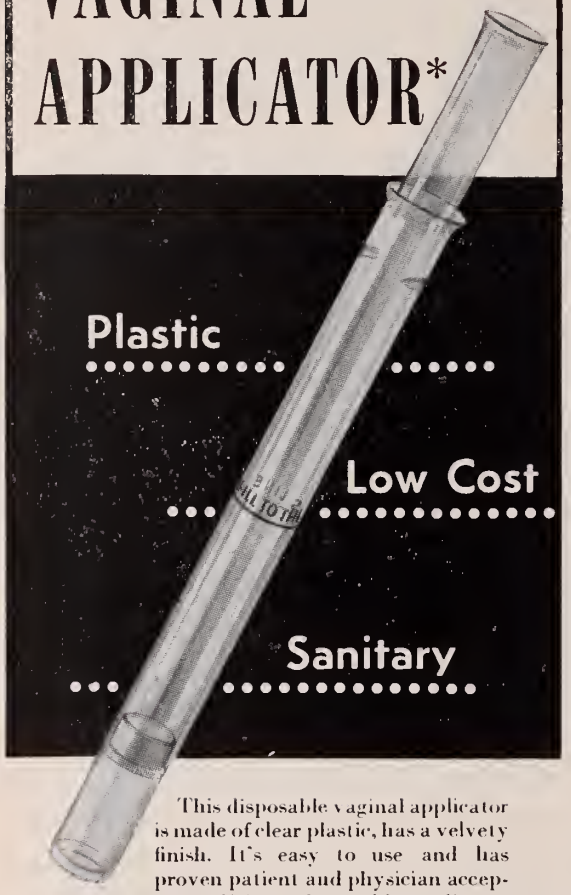
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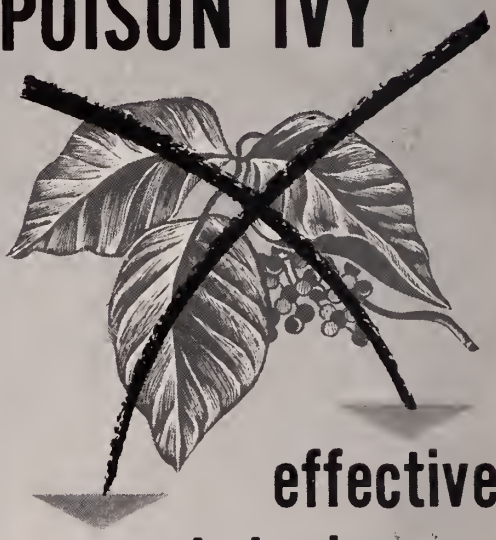
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base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium [illegible] phate, found much hig[illegible]

antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetracycline is re[illegible]o its ability to form comple[illegible]en unavailable for [illegible]he [illegible]th [illegible]h

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

[illegible]meta[illegible]

[illegible]ex.

[illegible]ddendum to the last mentioned paper of [illegible]ch et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the [illegible] of calcium as fillers in so[illegible]

[illegible]thers.

[illegible]is, however,

Editorial.
The New England Journal of Medicine.
258:97-99, (January 9) 1958.

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- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

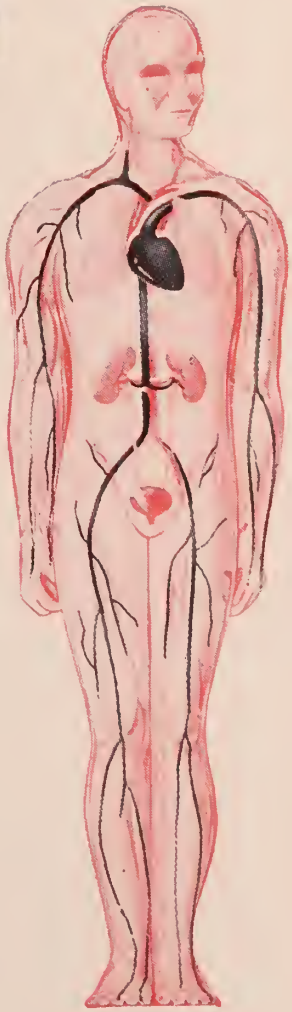
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in

HYPERTENSION



1 INITIATE 'DIURIL' THERAPY
'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS
The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION
The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

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In every human effort, time is of the ence. No single act, no brief moment in e sun, has ever overshadowed the life's rk of a master.

And as it is in the affairs of men, so it is in e world of commerce. Nothing great was er created suddenly.

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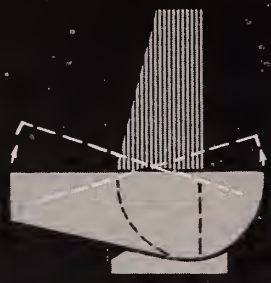
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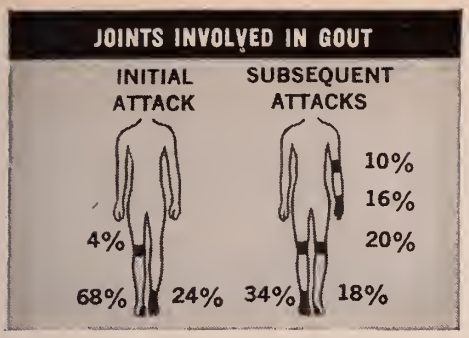
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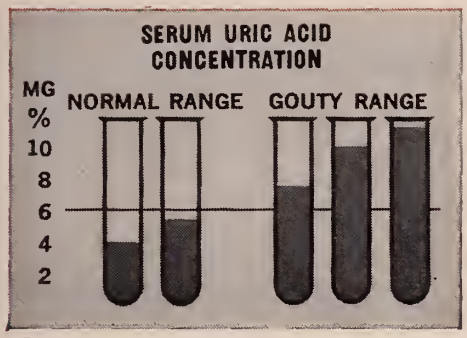
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1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



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4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

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*Silbert, N. E., Ciba Clinical Symposia; 6: 86; May 1954
Mechaneck, I., Annals of Allergy; 12: 164: March 1954
Rosen, F. L., J. Med. Soc. N. J.; 51: 110: March 1954
Mueller, H. L., & Hill, L. W., N. E. J. of Med; 249: 726, 1953



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CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

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Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

ACHROSTATIN V combines ACHROMYCIN† V ... the new rapid-acting oral form of ACHROMYCIN† Tetracycline ... noted for its outstanding effectiveness against more than 50 different infections ... and NYSTATIN ... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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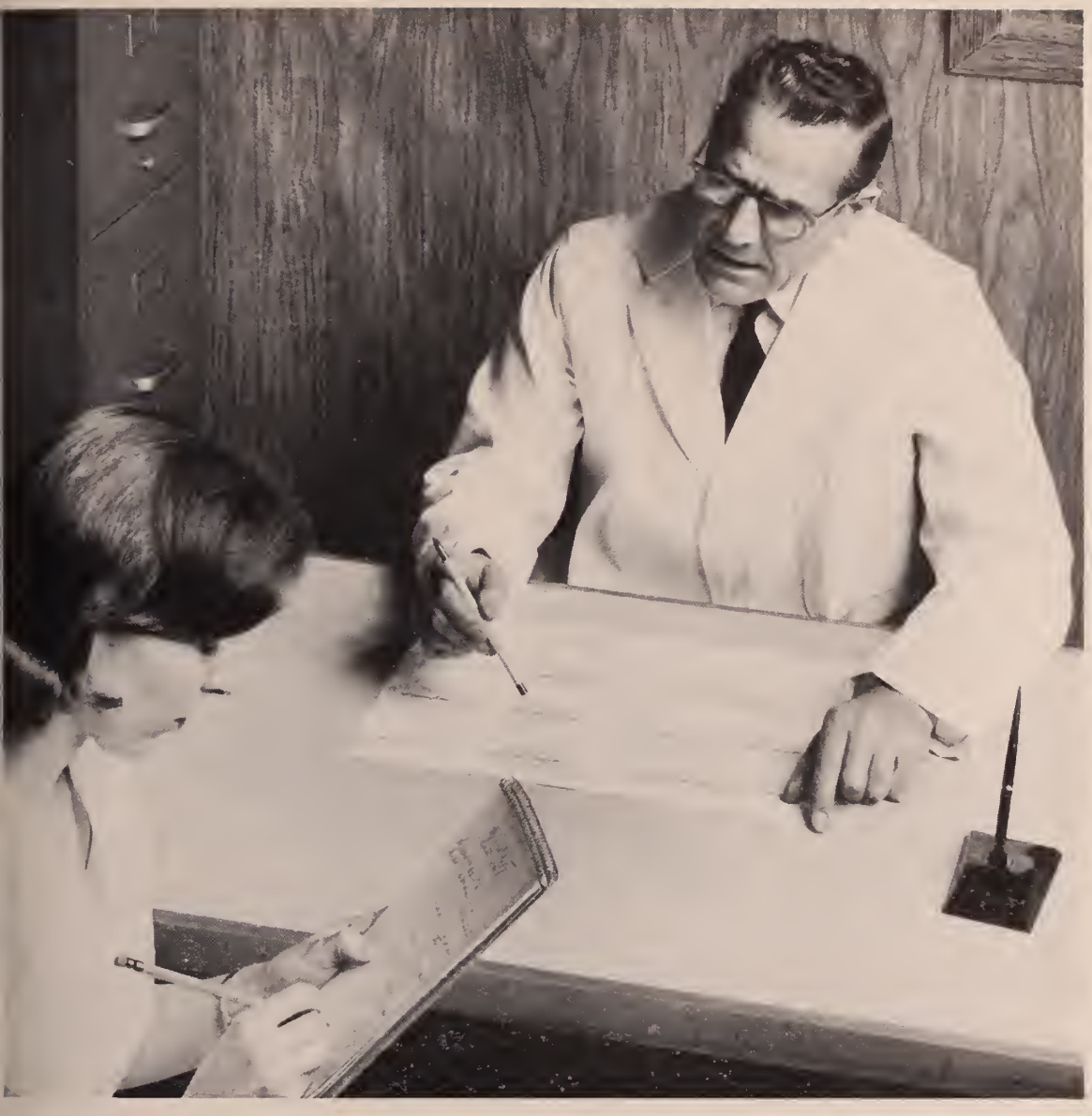
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* J.A.M.A. *166*:158,1958; Welsh,A.L. and Ede,M.
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* 1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P. and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.



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d, Calcium Pantothenate	5 mg.
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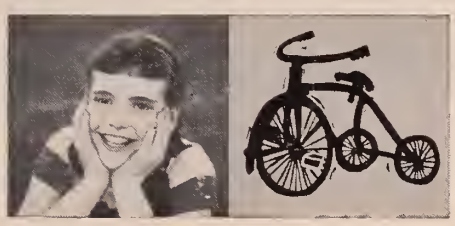
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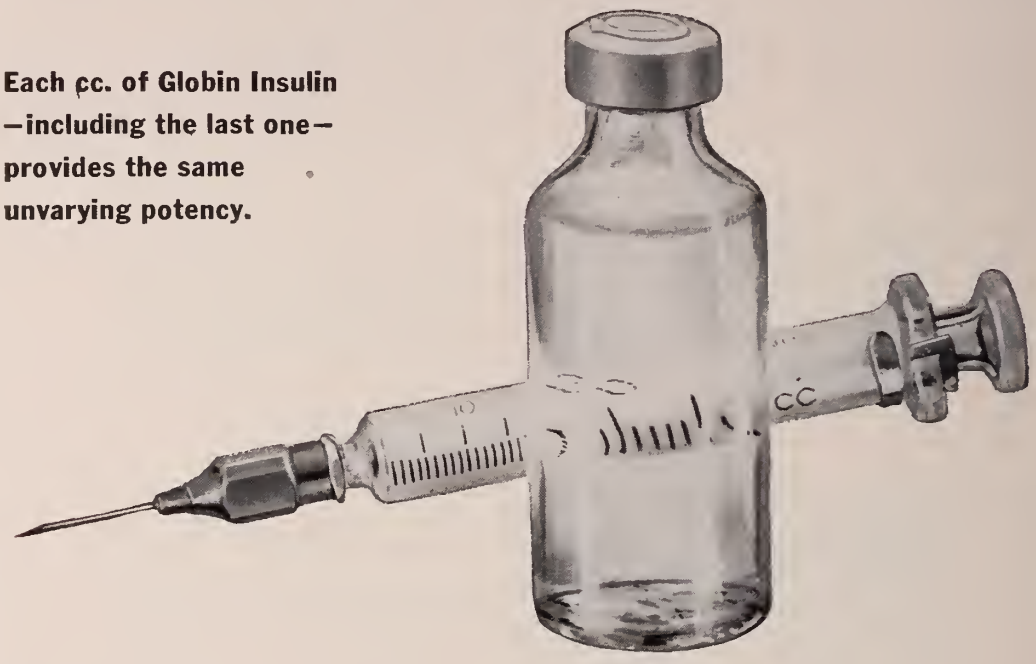
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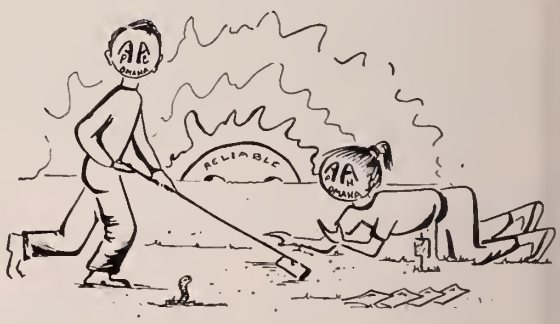
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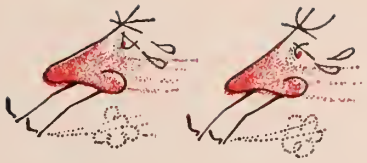
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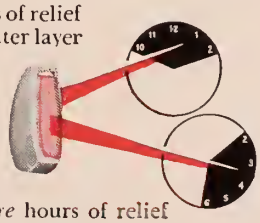
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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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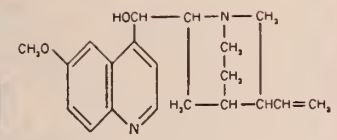
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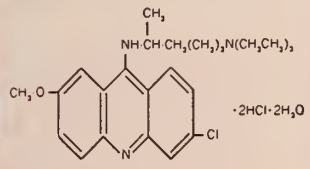
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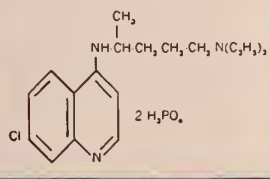
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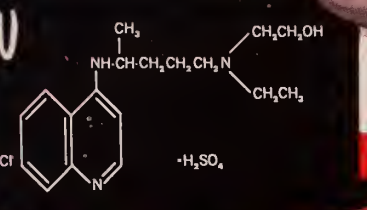
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A L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
A C., and Alexander, L.J.: The Schoch section, *Bull. A. Mil. Dermatologists* 5:25, Nov., 1956.
Theodore: Arch. Dermat. 73:572, June, 1956.

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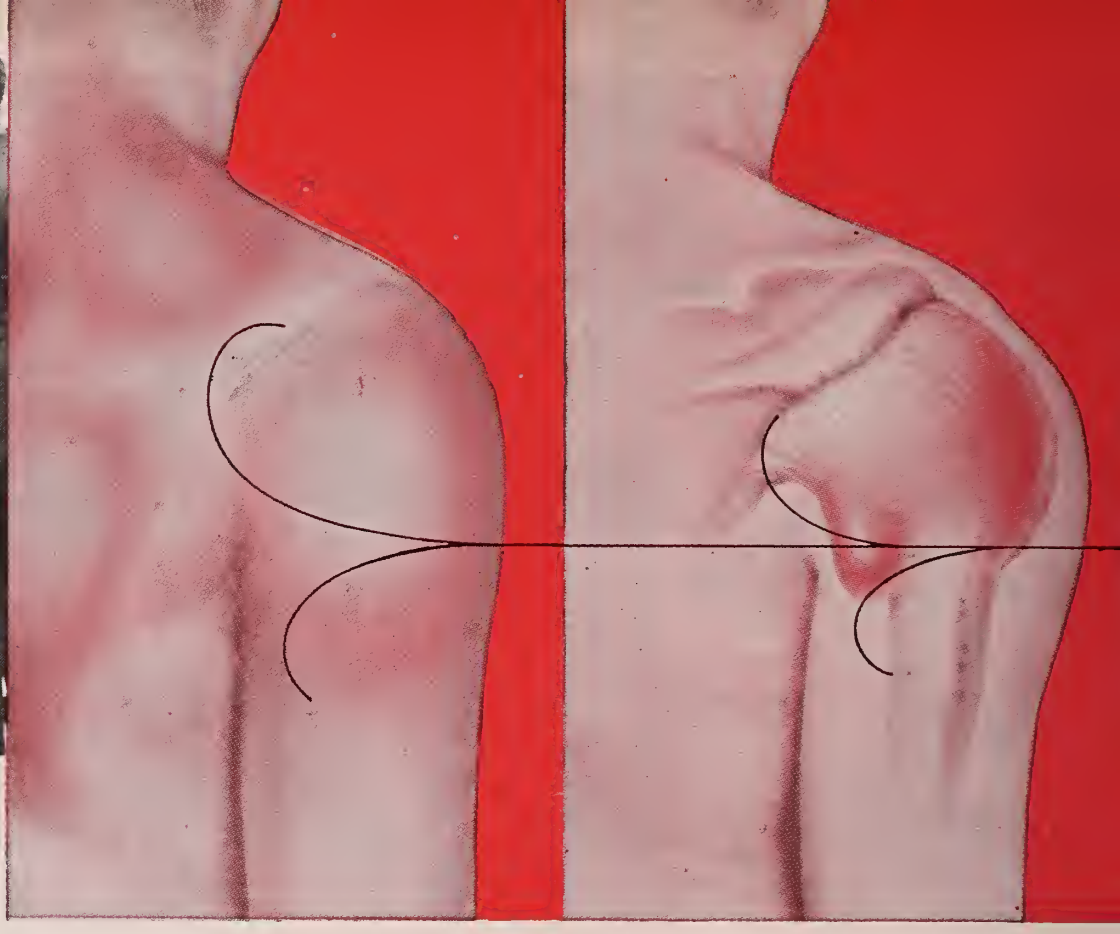
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References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49,1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

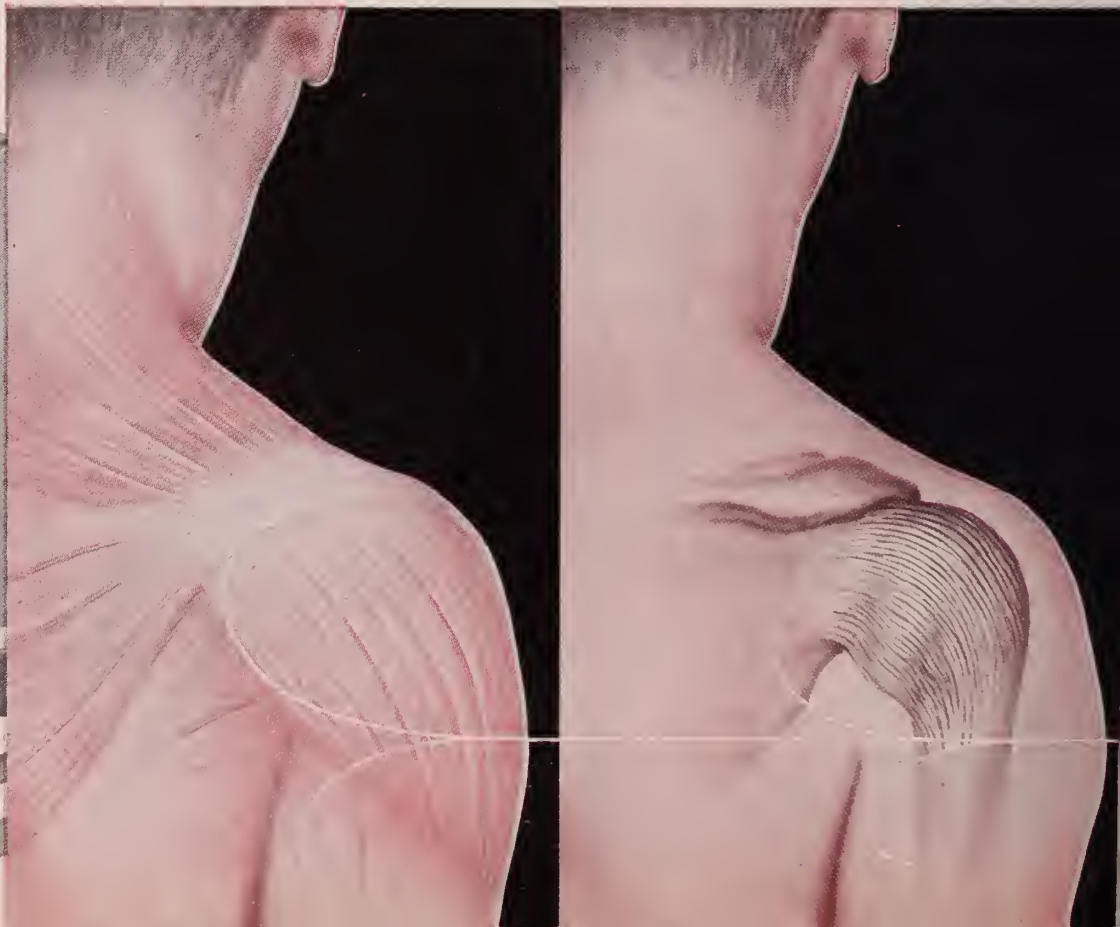
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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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(1) Noojin, R. O.: South. M. J. 49:149, 162:1379, 1956. (3) Goldman, L.; Flatt, 25:75, 1955. (4) Frank, L., and Stritzler, (5) Robinson, R. C. V., and Robinson, (6) Canizares, O.; Shatin, H., and Rosen 1955.

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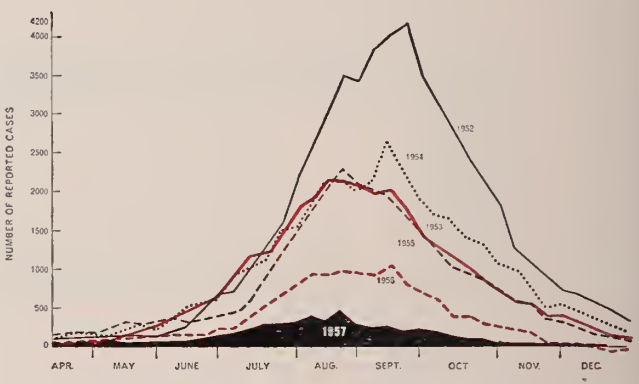
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1. J. A. M. A., 165:21 (November 23), 1957.

2. Department of Health, Education, and Welfare: News Release, October 10, 1957.



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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Albert B. Kump, 1908 - 1958



Next week was to have been his big moment: the accolade of The Medical Society of New Jersey, the presentation of the Fellow's key, the applause for a job well-done and the salute to the first citizen of New Jersey medicine. He will not see it. We are, at least, grateful that he lived to witness his installation as President of this Society even if he did not live to finish out his term.

Albert Barker Kump was born in Bridgeton in 1908. An alumnus of Blair Academy, he won his B.A. at Johns Hopkins in 1933 and his M.D. at the University of Maryland in 1938. After interning at Cooper Hospital in Camden, he returned to his native Bridgeton for private practice. There he served the people of Cumberland County from 1939 until his death last month. He was interested in many phases of medicine, and in 1946 was named chief of obstetrics at the Bridgeton Hospital. He was also medical director of the Bridgeton plant of Owens-Illinois Glass.

Dr. Kump was called to every office in the

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Cumberland County Medical Society and in 1954 was elected 2d vice-president of The Medical Society of New Jersey. In May 1957 he was installed as President of our Society. He was a Fellow of the International College of Surgeons, and only a year ago, was cited by the American Legion in Cumberland County as the citizen of the year, the man who had rendered the most outstanding service to the community. This award had in all previous years gone to a project, not an individual. But in south Jersey Albert Kump was not just an individual: he was a whole civic betterment project, a host in himself.

At the 1957 Annual Meeting, Dr. Allman gave the formal address introducing Dr. Kump. He deviated from his prepared talk, to read a letter from Mary Bacon. She wrote to Dr. Allman: "We will ask you to bring to life the warmth and strength that is Albert's. We have all come to depend upon him. Whenever I was over my head, I called him and he had one stock reply: 'I'll be right over.' And this he did for any and all, day and night. He placed community affairs, his patients, his hospital and his colleagues far above his own personal interests."

It is hard to improve on that requiem. Let it stand as his epitaph: *he placed these things far above his own personal interests.*

Atlantic City in the Spring

It seems as if every May this JOURNAL comes out with an editorial called "Atlantic City in the Spring." This seems to be the most attractive way of reminding you of the Annual Meeting. Other doctors come from all over the United States to attend meetings in Atlantic City, which is called "the playground of the world" with good reason. Since Atlantic City is in our own back yard, so to speak, it would seem odd if we New Jersey doctors did not appreciate this internationally famous magnet.

The Annual Meeting is the parliament of your profession. In addition to all the usual reasons for going, there are some special events in 1958. There is a symposium on medical care called "Challenge and Achievement," which, indeed, will be a challenge both to your thinking and to your action on the subject. Furthermore, this session will include a panel of participants from a variety of insurance companies who offer a number of different kinds of insurance coverage.

A motion picture theatre will run Monday, Tuesday and Wednesday afternoons and in addition to some brand new scientific films, will include the new AMA film on "The Doctor Defendant."

The impressive "Golden Merit Award" ceremony, which was such a success last year, will be held on Saturday, May 17.

In addition to the usual scientific sections, this year for the first time will have a section on "Preventive Medicine."

Another feature is the art exhibit of the Woman's Auxiliary. This is in addition to the usual two dozen scientific exhibits, six educational exhibits, and 71 technical exhibits.

All of this is set against the backdrop of a scientific program, a chance to meet old friends, a chance to be heard in the town meeting of your own profession, and a chance to enjoy a little rest and relaxation from the hum-drum activities of the office.

Why not?

Berthold E. Schwarz, M.D.

Bartholomew A. Ruggieri, M.D.

Montclair

Some Specific Causes of Delinquency and Sexual Deviations

In days of old, the family M.D. was often called on when the family was in any kind of trouble—not just medical trouble. The physician's growing but narrow interest in human machinery has made him, too often, a less useful familial confidant. Thus in the area here described, Dr. Schwarz and Dr. Ruggieri show how a canny doctor can look below the surface complaint.

In recent years there hase been a radical change in the concept of various forms of juvenile delinquency and psychopathic behavior. By the technic of collaborative research [1] and therapy,[2] two or more physicians undertake the simultaneous treatment of the parent and the child and possibly other members of the family. At frequent intervals they meet and compare material from their respective interviews. This painstaking technic has permitted these physicians to pinpoint the specific causes of a variety of emotional disturbances: school phobias,[3] fire setting, stealing, lying, truancy, homosexuality, transvestitism and other forms of deviant behavior.[4,5,6,7,8] Furthermore, other recent studies by this method have revealed new facts about such conditions as obesity,[9] schizophrenia,[10] and anorexia nervosa.[11]

The specific problem of the child is a reflection of highly specific problems in the emotional make-up of the parents. Thus society smiles indulgently as the parent receives understandable gratification from the socially commendable achievements of the child.

On the other hand, it is not generally recognized that a parent may also get gratification from the antisocial acts of his child. Thus,

1. Szurek, S. A., Johnson, A. and Falstein, E. I.: American Journal of Orthopsychiatry, 12:511 (July) 1942.
2. Schwarz, B. E. and Ruggieri, B. A.: Parent-Child Tensions, Philadelphia, J. B. Lippincott and Company 1957.
3. Johnson, Adelaide, Falstein, E. I., Szurek, S. A. and Svendsen, Margaret: American Journal of Orthopsychiatry, 11:702 (Sept.) 1941.
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7. Litin, E. M., Giffin, M. E. and Johnson, A. M.: Psychoanalytic Quarterly, 25:37 (January) 1956.
8. Schwarz, B. E.: Journal of Nervous and Mental Disease, 124:287 (Sept.) 1956.
9. Frazier, S. H., Faubion, M. H., Giffin, M. E. and Johnson, A. M.: Proceedings of the Staff Meetings of the Mayo Clinic, 30:227 (June) 1955.
10. Beckett, P. G. S. *et al.*: *Psychiatry*, 19:137 (May) 1956.
11. Giffin, M. E., Frazier, S. H., Robinson, D. B. and Johnson, A. M.: Proceedings of the Staff Meetings of the Mayo Clinic, 32:171 (April 17) 1957.

the parent with a poorly integrated emotional make-up may have an urge to act out in a manner which society would condemn. Fearing such condemnation, this parent does not act that way. Instead, he obtains vicarious gratification of these forbidden urges by subtly permitting or even encouraging his child to act out these antisocial and destructive impulses. The parent's destructive impulses are unconscious, and he is not aware of his role in communicating these urges to his child. The child reacts appropriately. This acts as a stimulus for further and more complex parent-child reactions. A cycle is established. As a result of the child's acting out the parent's forbidden impulses, society responds by condemning the child and commiserating with the parent. If the physician is going to be of any help to the parent and child, he must not sit in judgment. He must, rather, look further into the causes as he would with any other complaint. If he does so, he will realize that the parent's unconscious attitudes and behavior, healthy and unhealthy, are derived in turn from experiences with his own parents. Thus, the emotional attitudes of one generation are passed on to the next. A parent whose child is emotionally ill may therefore not be to "blame," but he is responsible for seeking help.

It is the purpose of this paper to describe some of the findings of collaborative therapy in the study of individual delinquency and sexual deviations. Although our findings would seem to indicate similar emotional factors in the group or "gang" delinquent, it is not the purpose of this paper to discuss this form of delinquency with its large element of social and economic causative factors.

Because of the prevalence of these emotional disorders, it is essential that every physician have a working knowledge of their genesis. At least, regardless of his branch of medicine, he should be able to recognize such problems in order to offer sympathetic cooperation to his psychiatric colleagues.

These patients (parents and children) are difficult to manage and often possess uncanny, if unconscious skill in securing the unwitting help of physicians and others about them in acting out their antisocial and destructive impulses. It is easier for the physician to understand and treat these problems if both partners who are involved in the delinquency (parent and child) are simultaneously seen by the bilateral and multilateral technic. It is usually of limited or dubious value to see only one partner to the delinquency.

WHY THE SPECIFIC DELINQUENCY

The child begins life with a clean "moral" slate with no predetermined tendency to do either right or wrong. He acquires his sense of values from his parents. Both the healthy and unhealthy aspects of the parent's conscience become those of the child. If the parent's conscience structure is defective (in the areas of lying and stealing, for example) the child will develop a similar limitation because of continual exposure to the parent's own defect. The foundations of a child's conscience appear in the first year of life. Development of his conscience structure continues throughout his formative years when he is totally dependent upon his parents for the satisfaction of both physical and emotional needs.

CASE ONE

Billy's mother received a phone call from the principal informing her that Billy had been truant many times. The mother blandly lied, telling the principal that her son had been absent because of frequent head colds. She did not inform her son of the phone call or of her dishonest excuse. Billy learned of his mother's deception from his brother. In this way Billy received permission for further truancy. He received from his mother permission for a mode of behavior that he might himself utilize on future occasions. Investigation by the physician revealed that this episode was only one of many that followed a similar pattern. Billy's mother, for example, lied to her husband about her budget; cheated at cards; and did not object when she discovered that after receiving his strict allowance from her, Billy went to his father "on the sly" for a supplementary allowance. On one occasion, when approached by the president of her club to help type some invitation cards, she excused herself with profuse apologies by saying she had a bad cold—and then immediately went to the pool for the day with Billy and his brother.

CASE TWO

Tommy's mother was greatly incensed when her son was gently chastised by the grocer for taking

a candy bar surreptitiously from the sales counter. In rage she shouted, "I can't do a thing with him. Even if he is my own son, he's just a no-good sneak and headed for trouble. But how can I blame him when these stores always leave things out where kids will be tempted to get at them?" As they reached the street, she turned to her son and muttered under her breath, "You're too dumb to steal; all you do is get caught and disgrace me." Tommy's mother gloats as she pockets the excess change that a saleswoman has inadvertently given her. The mother still gets Tommy into the movies at half price even though he is well over the "children's" age limit; and when she does not have the exact change for the church offering, she pretends to drop some change into the plate as it is passed by.

Fire setting, when subjected to collaborative study, reveals the unconscious specific parental permissiveness and encouragement present in other types of child delinquency.

CASE THREE

Larry terrorized the neighborhood by setting fires, the last of which included an attempt to ignite his playmate's hair. When Larry's distraught mother was seen by the physician, the first thing she said was that she used to play with matches as a child until she accidentally started a fire which "burned the house down." Her brother suffocated in the flames. Thereafter, whenever her father found occasion to punish her (which was often) he reminded her that she was responsible for her brother's death. Her aunt, who lived in the same household, tormented her in a similar manner. In later years, whenever the aunt visited her after her marriage and Larry's birth, the aunt recounted these earlier events in detail. Larry's mother said, "I was worried when Larry first began to play with matches, that he'd take after me. But my aunt told me not to worry, that he'd outgrow it just as I did."

Further study revealed that this mother had much rage and hatred toward her father. She found surcease from these repressed feelings by acting out through her son whom she identified with her father. Her lifelong awareness of her own past gave her the choice of the delinquency. By implicating heredity, she had a convenient excuse. Finding some relief of her inner tensions through her son, there was no need to involve her other children (who were daughters) in her acting out.

Sexual deviations are frequently associated with the crimes of juvenile violence so often reported in the press. For example, homosexuality, transvestitism and bestiality stem from parental confusions about their own sexuality. Physicians who study these cases by the bilateral or multilateral technic find that the parents are maladjusted sexually. As a result they turn to their children for a warped form of sexuality to gratify urges that cannot be satisfied with their mates because of the unrecognized illness of one or both of them. For example, what purpose was served when Mrs. B., following a fight with her husband and while still smoldering with emotion, immediately took a shower with her ten-year old son? Why did fourteen-year old Sally sleep in the same bed with her father while the mother has not slept in the same room for the past eight months because of his "terrible snoring?" What is the connection between Mrs. K.'s seductive behavior in lying scantily clad on the couch before her "goggle-eyed" fifteen-year old stepson and this boy's recent arrest for violence toward girls? Was there a relationship between a 46-year old divorced business woman's frequent detailed and lurid accounts to her son of "men's sexual relations with animals" and her son's later bestiality? Under the dubious and flimsy banner of being "modern" and "natural" such parents (and their children) practice household nudity while older children of one sex sleep, bathe and dress with the parent of the opposite sex. Under the guise of mother and father love, seductive whispers, kisses, caresses, fondlings and insinuations are shared between the parent and the child of the opposite sex in a manner that should be reserved for the relationships between the parents themselves. Such unhealthy, intimate relationships between parent and child can only create much anxiety and confusion. In such a situation the child is thrust into competition with the parent of the same sex for the attention of the parent of the opposite sex. The child is tantalizingly shown a road that cannot be followed to its ultimate end. The boy will never really fully supplant his father nor the girl her mother. In this competitive setting the small helpless child is forced to assume an adult-like role and yet maintain some vestige of a healthy parent-child relationship. His dilemma is that he is in competition with a bigger and stronger adult on whom he depends and whom he also respects and loves. As these conflicting forces combine, guilt, fear and anger appear in the child. Depending on the varying specific factors, he

will then resolve his increasing anxiety by the delinquency openly or secretively and usually subtly espoused by the parents.

Frequent allusions to past and present parental promiscuity and escapades provide the child with a blueprint for conduct applicable to himself should the occasion arise in the future. Frequent questioning about a child's sexual conduct while on "dates" will reveal a parent's doubts about the child's "morality." Such misgivings reveal to the child a mode of behavior that is not unalterably sealed off from him. Intense parental interest, by look or tone of voice, in any transgression by the child of society's moral code also constitutes parental permission for such misbehavior even though the parent may verbally decry and prohibit such deeds. The parent can communicate permission for sexual perversions by many other similarly subtle ways, as in the forms of delinquency already cited. These parent-child communications are so devious and difficult to detect that it has even been hypothesized that a "telepathic" rapport exists between parent and child.[12]

CASE FOUR

Sixteen-year old Bob was brought to the office on an emergency basis because of "homosexuality." Since hearing from the school principal a few days before, the mother had been very upset, unable to "sleep or concentrate on anything" and just had "to get to the bottom of things." The patient was in acute distress and spoke in halting phrases, "I'm in terrible trouble." He elaborated on his attraction for muscular boys and stated that he was "glad" he was "caught" since he had lived in fear for the previous four years. Paradoxically, he said that when his mother told him about the principal's call, she was very calm and merely said, "Your father and I understand your weakness; we want you to get help."

In further contrast to the mother's description of her shock on first hearing from the principal, the patient recalled a number of specific instances which suggested his mother's previous knowledge and permissiveness toward his deviant behavior. The mother had always been afraid that Bob would be injured in competitive sports and therefore actively encouraged his associating with boys with "intellectual and more refined cultural pursuits." She was extremely proud of her son's athletic physique and attributed it to his patient and tedious devotion to body building exercises with a few select friends. To show her interest she often suggested that he invite one of his "nice young friends" to spend the night with him in his room. She often told Bob that she was happy that he did not "waste (his) time running after girls like those roughnecks." One incident that Bob remembered vividly occurred one night two years before. When the mother opened the door to his bedroom, she found Bob and his boyfriend, unclothed, playing with each other on the bed. His mother's body tensed, her eyes blazed, and then she quickly turned around and softly closed the door. Nothing was ever said about this incident, and life continued as though nothing had ever happened. Later in the interview, while describing his father to the physician, Bob said, among many other things, "When I once asked, 'Mother, is Dad a homosexual?' she answered, 'I don't know.' "

The physician recognized the mother's crucial role in the development of her son's deviation. Bob's mother was the only girl in a family of four children. The family prided itself on her ability to compete successfully with boys on their own grounds. They fostered this proclivity by calling her "Mike" and encouraging her participation in weight lifting exercises to develop her muscles. During the interview, the mother flexed her biceps to prove her prowess to the physician.

As a girl, she went on camping trips to the Adirondacks with her father and brothers. When not in school, she wore her brother's "hand-me-down" clothes. Since Bob was four years old, his mother had been bringing him to physicians, because she feared that his testes were too small; she could never be convinced otherwise. She illustrated her present "excellent" relationship with her son by stating that they still shared many intimate confidences with each other. In addition to having her femininity disparaged by the men in her family, she had other evidences of serious psychosexual difficulties: tomboyishness, incapacitating dysmenorrhea and frigidity. In keeping with her need to dominate men, she married a passive ineffectual man. Bob's homosexuality was another expression of his mother's psychosexual difficulties.

From these examples, one can see that the selection of the specific delinquency or "perversion" by the parent depends upon factors in the parent's own past experiences. The means by which the parent permits and fosters the specific delinquency depends upon many subtle and devious forms of communication. Since delinquency represents a fine parent-child symbiosis, both the parent and the child must be seen in therapy. In this way one can break the destructive cycle wherein the emotional illnesses of one generation are inoculated onto the next.

74 South Mountain Avenue

12. Ehrenwald, Jan: New Dimensions of Deep Analysis: A Study of Telepathy in Interpersonal Relationships. New York, 1952. Grune and Stratton. pp. 155-162.

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Alopecia Areata and Other Common Scalp Problems*

Man's eternal quest (less often woman's) for a cure for baldness continues. Dr. Goldberg and Dr. Hanfling report that alopecia areata can be controlled by the injection of hydrocortisone suspension and hyaluronidase into the affected area.

Alopecia areata is a frequently seen scalp problem. It represents approximately one per cent of the dermatologic patients in our practice. According to Ginsberg's [1] classification of alopecia capitis, it is of unknown origin. Van Scott [2] recently reported that an inflammatory infiltrate can be found around the affected hair bulb. Since such infiltrates are inhibited by the corticosteroid drugs, this may account for their usefulness in this disorder. Emotional factors have often been considered an important cause of this condition, but a survey [3] conducted at the Veterans Administration Hospital, Lyons, N. J., a facility largely for psychiatric patients shows only the average number of alopecia areata cases.

Villaha and Rothman [4] in 1952 were the first to note the regrowth of hair in alopecia areata in patients given orally administered cortisone. Since some patients can develop severe organic disturbances on prolonged systemic cortisone medications, this method of treatment is considered unwarranted for the treatment of alopecia areata. Rony and Cohen [5] in 1955 demonstrated that the local injection of hydrocortisone suspension into the area of the alopecia areata was effective in bringing about the regrowth of hair. Efforts have been made to duplicate this by using iontophoresis to accomplish the same goal.[6] Various steroid preparations such as hydro-cortisone suspension in saline, buffered hydro-cortisone hemi-succinate, prednisolone hemi-succinate with mannitol, and prednisolone saline suspension were employed in this manner but were not effective. Highly concentrated fluorinated hydro-cortisone ointment was applied by inunction and was also without effect.

*Presented before the Session on Dermatology, The Medical Society of New Jersey, April 30, 1957.

†Merck & Co., and Pfizer Laboratories generously supplied all the steroid drugs used. Wyeth & Co. kindly supplied the hyaluronidase solution, Wydase®. Pitman-Moore kindly supplied the Capsebon®.

1. Ginsberg, Julius E. and Baristow, Bruce, M. D.: Exhibit on Alopecia Capitis, Amer. Acad. of Dermatology, Chicago, 1956.

2. Van Scott, Eugene: Exhibit on Reconstruction of Pilosebaceous Units. Amer. Acad of Dermatology, Chicago, 1956.

3. Herz, Philip: Personal communication to the author.

4. Villaha, C. J. and Rothman, S.: Journal of the American Medical Association, 150:546 (1952).

5. Rony, Hugo R. and Cohen, David M.: Journal of Investigative Dermatology, 25:285 (1955).

6. Goldberg, H. C.: Unpublished data.

Injections of hydro-cortisone suspension† similar to the technic of Rony and Cohen [5] brought about excellent regrowth of hair in the alopecia areata areas. Further observations showed that the injections were effective for periods of time varying from one to three months. Injections may be given at two to four week intervals until this frequently self-limited disease has arrested itself; or in order to keep it under control in less favorable conditions such as alopecia totalis. Patients frequently complained of discomfort caused by the slow absorption of the injected material. To overcome this, ½ cubic centimeter of hyaluronidase solution† (150 turbidity units per cubic centimeter) was added to 2 cubic centimeters of hydro-cortisone suspension. This produced wider and more rapid spread of the injection with better patient acceptance.

Baldness *per se,* is primarily due to hereditary factors. Endocrine stimulation by the testes and ovaries, also are important elements affecting hair growth and distribution. Age factors too, are important.

GENETIC rules control the pattern of premature baldness.[7] This pattern is one of sex-limited inheritance based on the effect of an autosomal gene that expresses itself differently in males and females. Affected males transmit the trait to about half their sons, but rarely to their daughters. Females as well as males transmit the trait. Males carrying this trait are usually bald. Females carrying this trait are usually not.

Dandruff ordinarily is easily controlled with commonly used drugs like Capsebon®, Sebizon®, Selsun® and Fostex®. More involved and resistant cases are usually of the seborrheic dermatitis and psoriasis group. Here additional therapy is necessary. A helpful development for controlling this group is Grenz ray. This is a super-soft form of radiation.

7. Curth, Helen: Exhibit on Introduction into Human Genetics. Amer. Acad. of Dermatology, Chicago, 1956.

Dermatitis from hair tints, permanents, and local applications of various medications and hair tonic is common. It responds rapidly when the irritants are removed. In severe cases a bland ointment and steroid drugs are most useful. Keratoses are easily removed by freezing with a freon preparation, Frigiderm® or dry ice and curetting the lesion free from the skin surface. Pediculosis of the scalp is often easily overlooked. It is readily treated when detected by the use of 5 per cent of D.D.T. powder, Kwell® gamma benzene hexachloride or Zylate®, benzyl benzoate emulsion. Hemangiomas of the scalp occur frequently in infants. The response to dry ice and sclerosing therapy is excellent. Resistant cases can be treated with radium. Surgical removal of these lesions on the scalp proper is usually diffcult. Herpes zoster of the scalp as elsewhere runs a self-limited course. Only symptomatic care is indicated.

Ringworm of the scalp is still a common endemic problem. The type picked up from animals is often self-limited within a few months and treatment by observation is adequate. The human contact type is very resistant to topical medications. If it does not get well within three to six months, this can be best treated by x-ray epilation which is remarkably effective in this disorder. Wood's black light helps to make the diagnosis easy in most cases because infected hairs show a bright, pale green fluoresence. Some types of ringworm of the scalp do not fluoresce under this diagnostic light and such cases must be diagnosed by microscopic examinations and cultures. These non-fluorescent problems are unfortunately becoming more common.

SUMMARY

ALOPECIA areata can be improved and controlled by the injection of hydro-cortisone suspension† and hyaluronidase† into the affected skin areas. Other common scalp problems are discussed, especially ringworm of the scalp.

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Epoxy Resin Dermatitis

New Jersey industry is making increasing use of ethoxylene resins. These may produce a dermatitis with characteristic signs and patch test. If this dermatitis is not swiftly controlled, serious sequelae may ensue.

During the past decade the electronics, airplane and automobile industries have been increasing their use of ethoxylene resins, most of which are polyethers containing terminal epoxy groups. Significant dermatologic problems may occur in the handling of these chemicals.

The industrial use of epoxy resins depends upon their property of adhesion, their resistance to stress and their ability to ward off corrosion. These substances are used for encapsulating electrical equipment, sealing condensers, sealing cable ends and for moulding compounds. They are also used for laminating purposes (binding together multiple layers of flat material such as Fiberglass®) and for reinforcing epoxy plastics.

The raw materials are usually supplied in the form of two components, resin and curing agent. The latter is termed a hardener or catalyst. The uncured epoxy resins such as araldite and scotch cast are viscous amber colored liquids at room temperature. The addition of a "curing agent" produces a weather and stress resistant solid. In practice, the ethoxylene resin is mixed with the catalyst or hardener immediately before use and then applied on the desired material by casting, brushing or injection. About 48 hours are required for "curing" to be completed.

Polyamine hardeners are primary irritants. Although they are considered sensitizers as well as irritants, the former property is less significant. The resins, however, present a greater hazard since they have a marked capacity for inducing epidermal sensitization. Although they may have an irritant effect, their allergenic property is more pronounced.

During a three-year period as consulting dermatologist to a radio and television manufacturer, I saw 35 cases of dermatitis presumably due to epoxy resins. Dermatoses due to the ethoxylene resins have been reported previously.* I wish to emphasize the *severity* of the reactions, and the failure to detect hardening in any of the cases.

Epoxy resin dermatitis in sensitized individuals handling these preparations usually develops on the exposed areas with the face, neck, forearms and hands commonly involved. Eyelids are often the earliest site of involvement with various portions of the face and the hands the areas most frequently involved. Rarely is the face involved without the eyelids being affected. At times the eyelids alone may be the site of allergic eczematous contact dermatitis and the disorder may resemble nail polish dermatitis.

The earliest manifestations of epoxy resin dermatitis are redness, edema, vesiculation and occasionally exudation. These are commonly associated with marked itching, espe-

*Savitt, L.: Archives of Dermatology and Syphilology, 71:212 (1955).

cially when the dermatitis involves the face. Occasionally itching of the eyes or face may precede the eruption.

Continued exposure to the uncured resins may cause the eruption to become widespread and very disabling. Several cases with generalized involvement have been seen that required steroid (prednisone) therapy in order to prevent a lengthy convalescence or a serious complication such as exfoliative dermatitis.

EPIDERMAL reactions follow contact with the liquid stage of the resin or with mixture of resin and hardener before curing is complete. The hardened or cured resin is innocuous as far as allergic eczematous reactions are concerned.

The skin reactions due to the hardeners have been due to the irritant effects of the catalysts. These have been usually confined to the hands. They have consisted of vesicular crusted patches, distributed mainly on the sides and tips of the fingers.

Positive patch tests using the liquid resin were obtained in all 35 cases. Control patch tests in normal individuals were negative. The severity of the patch test appeared to parallel the intensity of the eczematous reaction. The positive patch tests were well defined and often tended to persist for several weeks as erythema and scaling at the test site.

During this period of observation the epoxy resins appeared to possess a higher index of sensitization than the hardeners. The number of cases of epidermal sensitivity due to the resins far exceeded the number of cases due to the catalysts. This may have been due to the extra caution the workers exercised in handling the fuming hardeners as compared to handling the apparently benign ethoxylene resins.

In industry the problem is that of direct contact of the liquid materials with the skin. During the "curing" process heat is evolved which causes the chemicals to become airborne. Low concentrations of the resin or hardener vapors may induce a recurrence in a sensitized individual. The possibility of the resins in vaporized state has to be considered in persons who have become sensitized and are ready to return to work after their dermatitis has healed. This underlines the importance of well ventilated working areas in the processing of these products and the necessity of educating the worker in the care and protection of his skin.

The sensitizing capacity of epoxy resins is best illustrated by a report by Grandjean.† In a survey of factories making electrical equipment, Grandjean† reported that 164 out of 328 (exactly 50 per cent) of the workers using araldite exhibited dermatoses attributed to exposure to the liquid araldite or the hardener.

518 Cooper Street

†Grandjean, E.: British Journal of Industrial Medicine, 14:1 (1957).

Ear Wax Warning

Wax in a swimmer's ears—particularly in only one ear—may lead to even dangerous consequences, according to Selzer, a Philadelphia otolaryngologist.*

Dizziness sometimes occurs when cold water enters a swimmer's ears causing abnormal activity in the labyrinths. This dizziness may lead to an inability to tell the position of the body, panic or even drowning.

Selzer pointed out that dizziness resulting from wax in only one ear is not confined to swimmers. It also may occur when cold air reaches the labyrinth of only one ear.

*Selzer, A. P.: Archives of Otolaryngology (May) 1957.

Historical Article • • •

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The Man Who "Discovered" Coronary Thrombosis

James Brian Herrick, 1861-1954

These are the days of the mechanical medicine man: the practitioner who lets the laboratory do the diagnostic work for him. These, too, are the days of the anti-egg-head—the fear of intellectualism. Read here about an almost contemporary, whose diagnostic acumen we can all envy, and who had no fear of being considered an intellectual.

CORONARY thrombosis, it seems, is always with us . . . and always has been. Yet, less than four years ago, the man who made the first pre-mortem diagnosis of this, was still alive. Indeed, the disease was first clinically recognized in 1912—well within the life-time of most of today's physicians.

Until 1912, coronary thrombosis was a pathological oddity—something discovered at autopsy, but presumably not diagnosable clinically. In that year, a practitioner named James Bryan Herrick displayed enough diagnostic acumen to light up the clinical picture of coronary thrombosis. So began the carefully recorded case reports and concise descriptions to disseminate the knowledge of coronary disease. Although James Herrick has had a large number of students, a host of friends, and many admirers, it is appropriate to freshen our memories concerning this great man of medicine and the humanities.

Until 1912 when Dr. Herrick published the classical paper on *Clinical Features of Sudden Obstruction of the Coronary Arteries* in the May 14 Journal of the American Medical Association, coronary thrombosis was simply a pathologic curiosity. The paper was received with little enthusiasm yet Dr. Herrick never faltered in lecturing and crusading. Six years later, he reported two more cases with autopsies and included the experimental work of Fred M. Smith who tied off the coronaries of dogs. This work complemented by electrocardiograms and lantern slides impressed the Association of American Physicians and caused an awakening that started the concept of "heart disease" snow-balling.

Today the general recognition of coronary thrombosis is one of the most important contributions of modern American medicine. The intimate story of that 1912 case was reviewed again by Herrick in the American Heart Journal, January, 1944. Dr. Herrick—in 1912—saw a critically ill, 55-year old man. The symptoms were those that we recognize today as that of acute coronary thrombosis. Dr. Herrick believed the cause to be a thrombus in the anterior branch of the left coronary and this was verified several days later by an autopsy performed by Dr. Ludwig Hektoen. The diagnosis of this case was missed by such outstanding practitioners as Dr. Frank Billings

and Dr. John B. Murphy. This emphasizes the uniqueness of the diagnosis at that time and its outstanding importance.

One cannot diagnose a disease without knowing of its existence—for that reason the conception of its existence ante-mortem in the case of Dr. Herrick has dramatic significance. An interesting sidelight is this. Before the patient expired, Dr. John B. Murphy and Dr. Herrick spent the night in the same room so that they could be at the bed-side of the patient. This was the custom of the time, and it spotlights the vigorous practice of clinical medicine at the turn of the century. It should encourage the general practitioner to retain his old selfconfidence in independent observation and analysis of subjective symptoms. The identification of coronary thrombosis came from the bed-side and was made by a clinician in the truest sense of the word.

It is inspiring to recollect the significant events in the life of Dr. Herrick. Fortified with a good inheritance, James Bryan Herrick was born on August 11, 1861 in Oak Park, Illinois. He was brought up in a home with a high standard of righteous living in which honesty, the dignity of industry and respect for his fellow man were keynotes. On graduation from the first class of Oak Park High School he spent one year at Rock River Seminary before matriculating as a freshman at the University of Michigan. From Moses Coit Tyler, head of the department of English, he acquired a life long devotion to Chaucer and English literature. In later years he was to present to the Chicago Literary Club, of which he was a member, a spicy paper entitled "Why I Read Chaucer at Sixty." A decade later he published another paper on "Why I Read Chaucer at Seventy."

Dr. Herrick taught Greek, Latin and English literature for one year in Peoria and for several years in Oak Park High School. This knowledge stood in him in good stead later on in the writing of his many papers. On June 13, 1885 he matriculated at Rush Medical School on the advice of his family physician, John W. Tope. The strength of Rush even at this time was not in its buildings or laboratories but in the character of its faculty. At the head of the department of surgery was Moses Gunn who exerted influence on Parkes, Murphy, McArthur, Bevan, Harris and A. J. Ochsner. De Laskie Miller, professor of ophthalmology, was the leading oculist in the northwest, and was chiefly responsible for the founding of the Illinois Charitable Eye and Ear Infirmary. At the age of 26 Dr. Herrick gave the valedictory address and was ready to take the examinations of the Cook County Hospital. Here Herrick won the blue ribbon and had first choice of Service. The Cook County Hospital, staffed by the outstanding medical men of Chicago, offered a storehouse of experience that made it the prize internship of the midwest and west. The senior-junior system was in full swing and the rotation through Medicine, Surgery and the Middlar specialties was already in existence. At that time the major responsibility rested on the senior intern who emerged a selfconfident, competent and resourceful medical man. Herrick chose for his "Attendings" Drs. Christian Fenger and Norman Bridge. He enjoyed a rich personal relationship with them as well as with other high ranking physicians of the day. On the completion of his internship he continued an association with "County" as an Attending physician which lasted for twenty years. His weekly amphitheatre clinic became a model from which the famous clinics of Drs. Leroy Sloane, Portis, and Arkin and many others followed. Dr. Herrick never wavered in his affection for and acknowledged debt to the Cook County Hospital.

In 1889 Dr. Herrick married Zellah P. Davies and entered general practice on the west side of Chicago as an assistant to Dr. Charles Earle. He went into private practice for himself on November 1, 1890 and four years later went abroad to do graduate work in Prague. Then ensued a fertile period of practice, teaching and writing, and—in 1895—in the publication of a small *Handbook of Medical Diagnosis*. Dr. Herrick practiced medicine during one of the peaks of its development

in this country. He saw the almost complete elimination of typhoid fever, diphtheria, scarlet fever and yellow fever. In 1900 he limited his practice to consultation and to what is now known as "internal medicine." As a consultant he was especially clever at diagnosing empyema. With the diagnostic needle he developed an extraordinary skill in striking pus in the chest. In 1910 when he wrote his original article on coronary thrombosis he also reported original observations on sickle cell anemia. The entire field of medicine interested him.

To illustrate his protean clinical acumen and courage under fire the ensuing incident from his "Memories of Eighty Years" is revealing. He had diagnosed a peri-nephritic abscess and asked Dr. Murphy to operate. Dr. Murphy suggested that they present the case to an amphitheatre clinic first. After Herrick presented the history, Dr. Murphy asked him to point out exactly where he had inserted the needle. He then inserted one of his long needles but failed to strike pus. In front of the students Murphy turned and said, "Dr. Herrick, how is this? You say you got pus at this point, I don't. What is your explanation?" On the spot, with his face red, Herrick replied, "You are probably using a plugged needle." Upon examination of his needle sure enough he found it plugged with rust. Dr. Murphy turned to the students and said, "I think Dr. Herrick's diagnosis of the reason for the dry tap is as brilliant as his recognition of the abscess which I believe is there." Whereupon with a sly look he added, "Now I am going to let all of you in on a secret. I never go to a case without two exploring needles. One may break or be plugged, as this one is, from carelessness in cleaning. Let me have the other needle." He then withdrew pus to confirm the diagnosis and operated.

By reasons of inheritance, the age in which he lived, training and hard work, Herrick soon became a dominant medical figure in this country. Gaining confidence in the wards of the Cook County Hospital, sharpened and world-wise in the practice of medicine and enlightened by foreign travel he had the prerequisites for performing outstanding service. His mark of success was further assured by his basic knowledge and experience in English literature and the classics, and his clinical teaching of medical students and interns climaxed by the inspiration to do clinical research that he saw in high flower in the European clinics of Chiare, Pick, Nusser, Emil Fischer and others. His ideals, morals and dedication to medicine were developed to the uppermost levels and were maintained at their high pitch until the end.

After publishing his early articles on coronary thrombosis Herrick maintained a crusade of lecturing and writing* to bring the subject to the awareness of the profession. He conducted clinics and lectured throughout the country to graduate groups, preaching the gospel of coronary thrombosis. His papers are clinical gems, written clearly and succinctly with concise case histories. He gave a prognosis that is consonant with our thoughts today. During that day, heart disease was popularly believed to be an incurable affliction likely to cause sudden death and for which little could be done. To dispel this conception Dr. Herrick put his weight to the newly organized Heart Association. He encouraged the general practitioner and the specialist, and enlisted their cooperation. He explained the nature of the illness and that readjustment of living and working may transform the cardiac cripple into a wage earning, self-respecting citizen. He knew the wisdom of moderation and discouraged the stress and strain of "modern" high speed living. He stated that the most logical and efficient way to treat the chronic cardiac cripple is to annihilate the disease that causes the crippling. He envisaged the magnitude of the problem involving many contacts—from the home, the school, the factory to the social services, public health and vocational guidance. He foresaw prevention, early diagnosis and rehabilitation as the pillars in the treatment of coronary disease and in restoring the cardiac patient.

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*One was published in the October 1935 issue of this Journal (32:590). It is still, after the lapse of 23 years, readable, accurate and instructive.—*Editor*

Dr. Herrick served as officer of special boards including the Lewis Institute and the McCormick Memorial Institute. He was a founder of the Chicago Society of Internal Medicine, the Chicago Heart Association and other organizations, some of which he served as president. He was the recipient of the Distinguished Service Medal of the American Medical Association in 1939. Besides all these achievements he wrote engaging literary pieces and never lost an intimate habit of reading Chaucer. For his literary accomplishments he has been classed by William H. Holmes, who has written a fine appreciation of him, with Weir Mitchell and William Osler.

Dr. Herrick died on March 7, 1954 at the age of 92. He had received many honors tendered in recognition of his efforts in bringing the clinical story of coronary thrombosis to its present place in modern medicine and for fostering and actively stimulating others to carry on the work. Perhaps these lines of his cherished Chaucer may epitomize Herrick the man.

"Alas! that Ive had English, ryme or prose,
Suffisant this flour to preyse aryght!"

121 Market Street

Ataractic Classification Abandoned

The American Medical Association has abandoned the classification of remedies as tranquilizers or ataraxics and prefers a pharmacologic rather than a subjective system of classifying. This is explained* as follows:

It seems wise to bear in mind that regardless of terminology, the ideal objective of psychotherapy with drugs is to induce an improved mental state, irrespective of what subjective symptom or objective sign is being treated.

In accordance with the foregoing considerations, the Council has voted to abandon the section on ataraxics in *New and Nonofficial Drugs* and to describe agents proposed for use for their particular effects on the central nervous system, in accordance with their fundamental pharmacological classification. On the basis of present knowledge, the drugs in this general category can be classified under the following headings:

I. Antihistamines.
  A. Psychotherapeutic antihistamines
    a. Hydroxyzine (Atarax) hydrochloride

II. Central Nervous System Depressants
  A. Nonselective Depressants
    1. Analgesics
    2. General anesthetics
    3. Hypnotics and sedatives
  B. Selective Depressants
    1. Anticonvulsants
    2. Antihistamines (as above)
    3. Antitussives
    4. Central muscle relaxants (skeletal muscle relaxants), nonsedative
      a. Mephenesin (Avosyl, Dioloxol, Kinavosyl, Lissephen, Mephenesin, Mepherol, Mephson, Myoten, Myoxane, Oranixon, Prolax, Saserol, Sinan, Spasmolyn, Tolansin, Tolosate, Toloxyn, Tolserol, Tolulox, Tolyspaz)
      b. Mephenesin carbamate (Tolseram)
    5. Central muscle relaxants (skeletal muscle relaxants), sedative
      a. Meprobamate (Equanil, Miltown)
      b. Phenaglycodol (Ultran)
      c. Promoxolane (Dimethylane)
    6. Central parasympathetic suppressants
      a. Benactyzine (Suavitil) hydrochloride
    7. Central sympathetic suppressants, phenothiazine derivatives
      a. Chlorpromazine (Thorazine) hydrochloride
      b. Mepazine (Pacatal) hydrochloride
      c. Perphenazine (Trilafon) hydrochloride
      d. Prochlorperazine (Compazine) maleate
      e. Promazine (Sparine) hydrochloride
      f. Trifluprom azine (Vesprin) hydrochloride
    8. Central sympathetic suppressants, rauwolfia derivatives
      a. Alseroxylon (Rauwiloid)
      b. Deserpidine (Harmonyl)
      c. Rauwolfia (Raudixin, Rauserpa)
      d. Rescinnamine (Moderil)
      e. Reserpine (Rauloydin, Raurine, Reserpine, Reserpoid, Roxinoid, Sandril, Serpasil, Serpiloid)

III. Central Nervous System Stimulants
  a. Methylphenidate (Ritalin) hydrochloride
  b. Pipradrol (Meratran) hydrochloride

IV. Miscellaneous Agents
  a. Azacyclonol (Frenquel) hydrochloride

It is suggested that you copy this tabulation and keep it handy. It is a usable road-map through our newest pharmaceutical jungle.

*Journal of the American Medical Association, 166:1040 (March 1, 1958).

The 192nd Annual Meeting
OF
The Medical Society of New Jersey
HADDON HALL, ATLANTIC CITY
May 17, 18, 19, 20 and 21, 1958

Daily Schedule

Friday, May 16, 1958

8:00 p.m.—Board of Trustees
Bakewell Room, 1st floor

Saturday, May 17, 1958

12:00 noon—Registration Opens
Sun Porch, Lounge floor

2:30 p.m.—House of Delegates
Viking Room, 13th floor

3:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor

4:00 p.m.—Open Discussion on Medical-Surgical Plan
Viking Room, 13th floor

8:30 p.m.—Nominating Committee
Bakewell Room, 1st floor

Sunday, May 18, 1958

11:00 a.m.—Reference Committees:
"A"
Room 1333, 13th floor
"B"
Room 1344, 13th floor
"C"
Mandarin Room, 13th floor
"D"
Room 1335, 13th floor
"E"
Room 1337, 13th floor
Constitution and By-Laws
Bakewell Room, 1st floor
Miscellaneous Business
Rowsley Room, 1st floor
Resolutions and Memorials
Room 1332, 13th floor

4:00 p.m.—House of Delegates (election)
Viking Room, 13th floor

Monday, May 19, 1958

9:00 a.m.—Exhibits Open
Lounge floor

10:00 a.m.—House of Delegates
Viking Room, 13th floor

2:00 p.m.—Section on Obstetrics and Gynecology
Viking Room, 13th floor
Motion Picture Theatre
West Room, 13th floor

6:00 p.m.—Dinner—New Jersey Medical Women's Association
Bakewell Room, 1st floor

8:00 p.m.—General Session
Viking Room, 13th floor

Tuesday, May 20, 1958

9:00 a.m.—Board of Trustees
Bakewell Room, 1st floor

9:30 a.m.—Section on Cardiovascular Diseases
Room 1344, 13th floor

10:00 a.m.—Sections:
Clinical Pathology
West Room, 13th floor
Dermatology
Tower Room, 13th floor
General Practice
Viking Room, 13th floor
Pediatrics
Roberts Room, Chalfonte
Preventive Medicine
Mandarin Room, 13th floor
Radiology
Blue Room, Chalfonte
Rheumatism
Rutland Room, 1st floor
Urology
Zodiac A, Chalfonte

12:30 p.m.—Luncheons:
Section on Dermatology
Bakewell Room, 1st floor
New Jersey Academy of General Practice
Parlor A, Chalfonte
Professional Education Committee, New Jersey Heart Association
Room 1332, 13th floor
Section on Radiology
Zodiac B, Chalfonte
Section on Rheumatism
Navajo Room, 15th floor
Section on Urology
Rowsley Room, 1st floor

2:00 p.m.—Section on Medicine
Viking Room, 13th floor
Motion Picture Theatre
West Room, 13th floor

4:30 p.m.—New Jersey Society of Internal Medicine
Mandarin Room, 13th floor

5:30 p.m.—Medical Alumni, University of Maryland
Tower Room, 13th floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge floor

Wednesday, May 21, 1958

9:30 a.m.—Sections:
Allergy
Mandarin Room, 13th floor
Gastroenterology and Proctology
Blue Room, Chalfonte

10:00 a.m.—Sections:
Chest Diseases
Viking Room, 13th floor
Metabolism
Rutland Room, 1st floor
Neuropsychiatry
West Room, 13th floor
Ophthalmology
Zodiac A, Chalfonte
Orthopedic Surgery
Room 1344, 13th floor
Otolaryngology
Zodiac B, Chalfonte

12:30 p.m.—Luncheons:
Section on Allergy and New Jersey Allergy Society
Bakewell Room, 1st floor
Section on Chest Diseases and New Jersey Chapter, American College of Chest Physicians
Navajo Room, 15th floor
Section on Metabolism and Medical Members, New Jersey Diabetes Association
Rowsley Room, 1st floor
New Jersey Academy of Ophthalmology and Otolaryngology
Tower Room, 13th floor
Section on Orthopedic Surgery and New Jersey Orthopaedic Society
Parlor A, Chalfonte
Section on Surgery and New Jersey Chapter, American College of Surgeons
Vernon Room, Lounge floor

2:00 p.m.—Section on Surgery
Viking Room, 13th floor
Motion Picture Theatre
West Room, 13th floor

3:00 p.m.—Exhibits and Registration Close
Lounge floor

Golden Merit Award Ceremony

Saturday Afternoon, May 17, 1958

Viking Room, 13th floor

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding
Albert B. Kump, M.D., President

Master of Ceremonies
John F. Kustrup, M.D., Chairman, Subcommittee on Public Relations

Marshals
Presidents of component societies whose members are receiving awards

1958 Recipients
Atlantic County
Samuel E. Weiner, M.D., Atlantic City
Camden County
Mabel S. Haines, M.D., Audubon
Ralph K. Hollinshed, M.D., Westville
David S. Rhone, M.D., Mount Ephraim
Essex County
Joseph Albano, M.D., Newark
Abraham J. Alexander, M.D., Newark
Rush C. Bauman, M.D., Nutley
John Huberman, M.D., Newark
Otto H. Leber, M.D., Montclair
Otto G. Matheke, M.D., Newark
Jesse E. Proctor, M.D., Newark
Albert S. Tenney, M.D., East Orange
Edward P. Whelan, M.D., Nutley
Gloucester County
Henry L. Sinexon, M.D., Pitman
Hudson County
Michele Auriemma, M.D., Hoboken
H. Ameroy Hartwell, M.D., Weehawken
Louis C. Lange, M.D., Weehawken
Mercer County
Lawrence H. Rogers, M.D., Trenton
Monmouth County
George G. Reynolds, M.D., Freehold
Ocean County
Eugene G. Herbener, M.D., Lakewood
Passaic County
Hagop K. Beshlian, M.D., Preakness
William M. Fielding, M.D., Waldwick
John H. Gould, M.D., Ridgewood
Ernest Reeves, M.D., Passaic
William Tomkins, M.D., Ridgewood
Union County
John E. Runnels, M.D., Scotch Plains

General Session

Monday Evening, May 19, 1958

Viking Room, 13th floor

8:00 p.m.

Welcome
Albert B. Kump, M.D., President

Inaugural Address
Kenneth E. Gardner, M.D., President-Elect

Symposium—Medical Care Coverage: Achievement and Challenge

Moderator
Daniel F. Featherston, M.D., Chairman, Judicial Council, and Special Conference Committee on Health Insurance

Blue Cross-Blue Shield Plans
Irving P. Borsher, M.D., Trustee, Medical-Surgical Plan of New Jersey

Medicare Program
Major General Paul I. Robinson, M.C., Executive Director, Office for Dependents' Medical Care

Commercial Insurance Programs
Ardell T. Everett, Second Vice President, The Prudential Insurance Company of America

Legislative and Labor Programs
David B. Allman, M.D., President, American Medical Association

Question and Answer Period

Dinner-Dance

Tuesday Evening, May 20, 1958

Vernon Room, Lounge floor

7:00 p.m.

honoring

PRESIDENT AND MRS. ALBERT B. KUMP

Toastmaster
David B. Allman, M.D., President, American Medical Association

Welcome
Mrs. John C. Voss, President, Woman's Auxiliary

Introductions
Mrs. A. Guy Campo, President-Elect, Woman's Auxiliary
Kenneth E. Gardner, M.D., President-Elect

Guest of Honor
Albert B. Kump, M.D., President

Entertainment
Golden Memories of the Past Fifty Years
Lanny Ross
Accompanist, Al Ulin

Music
Joseph Stern's Orchestra

Motion Picture Theatre

Monday Afternoon, May 19, 1958

West Room, 13th floor

2:00 p.m.

Diagnosis and Office Management of the Arthritides

Merck Sharp & Dohme, Philadelphia, Pa.

The film shows a series of patients in the various stages of rheumatoid, osteo, and gouty arthritis. Differential diagnosis of these conditions is described and treatment is designated.

2:35 p.m.

Drug-Induced Depression—Fact or Fallacy

Ciba Pharmaceutical Products, Inc., Summit, N.J.

The film utilizes a scientific exhibit as visual support to Dr. Ayd's presentation on the difference between endogenous depression and over-tranquilization. Differential diagnosis and treatment of these conditions form the main part of the film.

3:00 p.m.

The Doctor Defendant

American Medical Association, American Bar Association; and the Wm. S. Merrell Company, Cincinnati, Ohio

The film deals with the subject of medical professional liability and depicts four representative situations confronting the average physician. The purpose of the film is to attempt to suggest preventive measures which will curtail the incidence of professional liability claims.

3:35 p.m.

Control of Severe Pain

Hoffmann-LaRoche, Inc., Nutley, N. J.

Pain has always been a basic problem in the relationship between the physician and the patient. In the practice of medicine, the relief of pain often may be as important as the diagnosis and treatment of the underlying disease itself. While moderate pain can usually be relieved without difficulty, the relief of severe pain still requires careful consideration. This film shows how several analgesics which act on the central nervous system control severe pain. It discusses certain aspects which the physician should consider before selecting an analgesic. It also shows how analgesic properties are evaluated in the laboratory, and it dramatically demonstrates the side effects of some of these drugs.

4:10 p.m.

Stress and the Adaptation Syndrome

Pfizer Laboratories, Brooklyn, N. Y.

Presents the concept of stress as developed by Dr. Hans Selye, by recapitulating the original experiments and interpretation of them which led to the recognition of non-specific biological stress in 1936. Shows the more recent work which developed from the study of stress.

Tuesday Afternoon, May 20, 1958

2:00 p.m.

The Meti Steroids in Rheumatoid Arthritis

Schering Corporation, Bloomfield, N. J.

This film reviews the chemistry, physiology, and clinical application of the steroid hormones in the treatment of rheumatoid arthritis and other collagen diseases. The film portrays the commonly accepted theories of adrenal cortico-steroid therapy and reflects most current knowledge on the subject.

2:30 p.m.

Hypothyroidism

Warner-Chilcott Laboratories, Morris Plains, N. J.

Covers full range of thyroid disorders. Physiology, diagnosis, and therapy are discussed and illustrated by actual cases. Current concepts in diagnostic problems and methods are emphasized.

3:05 p.m.

The Doctor Defendant

(Repeat — see Monday schedule)

3:40 p.m.

Operative Cholangiography

Winthrop Laboratories, New York, N. Y.

The procedure for x-ray visualization of the biliary tract at the time of surgery and postoperatively is shown step by step. The necessary equipment is demonstrated as well as the technic as applied in several patients. The film includes a discussion of sources of error in interpreting direct cholangiograms. Examples of preoperative oral gall bladder and duct visualization are also shown.

4:05 p.m.

Vaginitis

Ortho Pharmaceutical Corporation, Raritan, N. J.

The film deals with four main types of vaginitis —1. Trichomonas Vaginalis Vaginitis, 2. Mycotic Vaginitis, 3. Non-specific Vaginitis, and 4. Atrophic Vaginitis. Clinical cases representative of each type of vaginitis are shown before and after treatment. The symptoms of each type of vaginitis are reviewed. A simple, rapid diagnostic procedure is suggested. Current methods of treatment are outlined and the value of each method is discussed.

Wednesday Afternoon, May 21, 1958

2:00 p.m.

William Harvey and the Circulation of the Blood

Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y.

A reenactment of the Harveian experiments of three hundred years ago developed from Harvey's own published words and from his acute but currently simple experiments.

2:35 p.m.

Disorders of the Heart Beat

American Heart Association, and Wyeth Laboratories, Philadelphia, Pa.

The mechanics of the normal heart are described and illustrated; next the mechanics of certain abnormal phenomena are described and related to their EKG tracings. The appropriate heart sounds are reproduced as heard through a stethoscope, thus completing the correlations basic to differential diagnosis. Descriptive booklet available through Wyeth.

3:00 p.m.

The Doctor Defendant

(Repeat — see Monday schedule)

Film program arranged and presented through the cooperation of Paul Klemtner & Company, Inc., Newark, N. J.

Scientific Sections

Monday Afternoon, May 19, 1958

OBSTETRICS AND GYNECOLOGY

FREDERICK J. FAUX, M.D., Chairman, Woodbury
RUDOLPH C. SCHRETZMANN, M.D., Secretary, Bergenfield

Viking Room, 13th floor

2:00 p.m.

Bleeding Factors Relating to Obstetrical and Gynecologic Patients

Hemologic Aspects

John W. Frost, M.D., Assistant Professor of Clinical Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Discussor: Stewart F. Alexander, M.D., Park Ridge

Hypofibrinogenemia is perhaps the most frequently encountered coagulation defect seen in obstetrical and gynecologic practice. There are numerous other coagulation factors that may be lacking which if recognized prior to surgery or delivery, may be corrected by proper replacement therapy. The pre-operative or antepartum preparation of the patient with a hemorrhagic tendency is dependent upon proper knowledge of the coagulation defect involved and proper specific replacement of the lacking coagulation factor. The various coagulation defects will be presented along with a discussion of the laboratory tests used to delineate the defect and the specific substances used for replacement.

Obstetrical Aspects

Robert C. McElroy, M.D., Assistant Professor of Clinical Obstetrics and Gynecology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Discussor: Robert A. Cosgrove, M.D., Jersey City

The obstetrical aspects of coagulation defects with special reference to hypofibrinogenemia are discussed. Two illustrative cases, their treatment and results in abruptio placentae and dead fetus syndromes are presented.

A review of the recent literature is presented concisely with a discussion of the probable theories in producing defibrination of blood. Diagnostic laboratory methods are outlined for either complete or limited facilities. Practical methods of study and treatment are presented to safeguard the obstetrician against a too hasty intervention in terminating pregnancy in these syndromes.

Gynecologic Aspects

Hammell P. Shipps, M.D., Chief of Gynecology, Cooper Hospital, Camden

Discussor: Peter J. Bonanno, M.D., Teaneck

Bleeding from the female genital tract is a symptom frequently confronting every physician, and demanding differential diagnosis.

The gynecologic aspects of abnormal bleeding will be considered under the following causes:

(1) Dysfunction
(2) Trauma
(3) Pregnancy Complications
(4) Neoplasia
(5) Infection
(6) Atrophic Processes
(7) Systemic Diseases
(8) Psychologic Factors

For practical reasons it will be approached under the following arbitrary age groupings:

(1) Before Puberty
(2) At Puberty
(3) During Reproductive Life
(4) At the Menopause
(5) Postmenopausal

4:00 p.m.

Business Meeting

CARDIOVASCULAR DISEASES

PETER H. MARVEL, M.D., Chairman, Northfield
SIDNEY R. ARBEIT, M.D., Secretary, Jersey City

Room 1344, 13th floor

9:30 a.m.

The Treatment of Shock in Myocardial Infarction
Arthur Bernstein, M.D., Attending in Medicine, Newark Beth Israel Hospital, Newark
Co-authors: Franklin Simon, M.D., Bernard Robins, M.D., and Fred Cohen, M.D., Newark
Discussor: Norman Reitman, M.D., New Brunswick

Cardiogenic shock is still a very serious complication of myocardial infarction. Methods of therapy so far employed all have certain disadvantages, particularly ineffectiveness with some, need for careful titration, development of slough, and arrhythmias with others. In order to find a better therapy, mephentermine has been used in doses of 45-60 mg. intravenously, followed by an intravenous drip containing 600 mg. in 500 cc. of glucose in water. With this regimen we were able to correct shock in 64 per cent of cases of myocardial infarction with a 24 per cent recovery rate. In addition, we were able to correct several types of arrhythmias during the therapy.

10:00 a.m.

Physiopathologic Derivations of Electrocardiographic Patterns
William Likoff, M.D., Chief, Department of Medicine, The Hahnemann Medical College and Hospital, Philadelphia, Pa.

11:00 a.m.

Clinical Observations with Chlorothiazide as a Diuretic and Hypotensive Agent
Marvin C. Becker, M.D., Chief, Cardiac Clinic, Newark Beth Israel Hospital, Newark
Discussor: Jerome G. Kaufman, M.D., Newark

In the search for an oral preparation to replace the inconvenient mercurial injections, chlorothiazide was studied in 50 patients in severe congestive failure at the Newark Beth Israel Hospital Cardiac Clinic. It was determined that chlorothiazide was a potent, non-toxic diuretic. Parenteral mercurials could be discontinued in 60 per cent of the patients. In the others organic mercurial injections were substantially reduced.

Twenty-five (25) hypertensive patients were studied by a double blind technic in order to determine the potentiating effect of chlorothiazide on other hypotensive agents. These studies will be reported.

11:30 a.m.

Experience with Routine Cardiac Monitoring and a Cardiac Arrest Team in a General Hospital
Victor Parsonnet, M.D., Adjunct in Surgery, Newark Beth Israel Hospital, Newark
Discussor: Louis J. Cheskin, M.D., Newark

There are approximately 10,000 cases of cardiac arrest in the United States each year, with a 70 per cent mortality rate. Many of these deaths have been from prolonged cerebral and myocardial anoxia due to delay in diagnosis and therapy. Since the occurrence of cardiac arrest is largely unpredictable, and since immediate diagnosis is imperative, a cardiac monitor and alarm device has been used routinely for every anesthetized patient at the Newark Beth Israel Hospital for the past eight months. The preliminary encouraging results of this work will be presented. The value of the monitoring system in the prevention and treatment of cardiac arrest, and details of the organization and function of a hospital cardiac arrest team will be discussed.

12:00 noon

Business Meeting

CLINICAL PATHOLOGY

MURRAY W. SHULMAN, M.D., Chairman, Newark
MILTON ACKERMAN, M.D., Secretary, Atlantic City

West Room, 13th floor

10:00 a.m.

Electrophoretic Mobility of Hemoglobins
Thomas K. Rathmell, M.D., Attending Pathologist, The Mercer Hospital, Trenton
Co-Authors: Jorge Mora, M.D., and Thomas V. Egan, M.T., Trenton
Discussor: Murray W. Shulman, M.D., Newark

This presentation deals with the technical aspects of paper electrophoresis of hemoglobins. It outlines in detail the methodology to be used by the technician responsible for these studies. It illustrates their utility and diagnostic value for the clinician as well as providing some original research findings pertaining to the methodology.

10:30 a.m.

Business Meeting

10:40 a.m.

A Clinical Pathologic Conference

Clinical Presentation: Coleman B. Rabin, M.D., Attending Physician for Chest Diseases, Mount Sinai Hospital, New York, N. Y.

Pathologic Discussion: Solomon Weintraub, M.D., Director of Laboratories, St. Francis Hospital, Trenton

The case for this Clinical Pathologic Conference is one of an adult white male who was treated by his physician for unexplainable back pain for a considerable length of time, after which he was admitted to a University hospital for observation and diagnosis. At this institution he was carefully studied by x-ray and laboratory examinations. During his stay at the hospital no definite organic pathology was demonstrated and it was suggested that he be seen and treated by a psychiatrist. This was done and the psychiatrist, after several conferences with the patient as well as information received from members of the patient's family, concluded that the patient was not suffering from a psychiatric condition but rather from some disease of an organic nature.

The patient was then admitted to a second hospital. Further x-rays and laboratory tests were performed. These revealed metastatic neoplasm of the spine, ribs and sternum. Tumor cells were found in the sternal bone marrow. These were said to have been of metastatic nature. At this second hospital no definite recognizable primary tumor could be demonstrated. The postmortem examination reveals not only other metastatic lesions but also the primary nature of the disease.

11:30 a.m.

Treponemal Tests in the Serodiagnosis of Syphilis

George H. Kostant, M.D., Associate Professor of Dermatology, New York University Post-Graduate Medical School, New York, N. Y.

Guest Discussor: Elmer L. Shaffer, Ph.D., Director, Division of Laboratories, New Jersey State Department of Health, Trenton

Attention is directed to the increasing importance of biologic false positive (BFP) reactions in standard serologic tests for syphilis. The Treponema Pallidum Immobolization (TPI), Treponema Pallidum Immune-Adherence (TPIA), Treponema Pallidum Complement-Fixation (TPCF) and Reiter Protein Complement-Fixation (RPCF) Tests are described as methods differentiating the BFP reaction from the true syphilitic one. The relative advantages and disadvantages of these four test procedures are discussed as well as their clinical evaluation and interpretation. It is emphasized that the prime indication for serologic tests employing treponemal antigens is the differentiation of BFP from true syphilitic reactions, and that these procedures may *not* be used as a criterion of cure or syphilitic activity.

DERMATOLOGY

Francis J. McCauley, M.D., Chairman, Newark
Everett V. Dulin, M.D., Secretary, East Orange

Tower Room, 13th floor

10:00 a.m.

The Physician's Role in the Care of the Skin

Eva T. Brodkin, M.D., Attending Dermatologist, St. Barnabas Medical Center, Newark

An excessively dry or excessively oily skin is a social handicap and an occupational hazard. The fact that both types predispose to certain specific dermatoses makes it incumbent on the physician to recognize them and to advise the patient how to properly care for his skin.

The causes, the alleviation of the attendant discomfort and the prevention of the resulting dermatoses are discussed with special attention to prevention of dermatitis of the hands and to the prevention of acne vulgaris in adolescent children.

10:20 a.m.

Statistical Study and Treatment of Various Types of Malignancy of the Skin (illustrated)

Bart M. James, M.D., East Orange; Attending Dermatologist, St. Michael's Hospital, Newark

Co-Author: John A. Hunt, M.D., East Orange

The various types of pre-cancerous and cancerous skin lesions and new growths are discussed and differentiated as to etiology, location, frequency, and pathology. The tendency to remain local or metastasize is taken into consideration. Various methods were used in treating the malignancies. A statistical follow-up three to five years or more is presented concerning the type of malignancy and the results. The study will include 205 senile keratoses, 968 basal cell epitheliomas, 162 squamous cell epitheliomas, and 26 nevocarcinomas.

10:40 a.m.

The Place of Radiation and Isotope Therapy in Modern Dermatologic Treatment

Paul R. Kline, M.D., Trenton; Associate Clinical Professor of Dermatology, New York University Post-Graduate Medical School, New York, N. Y.

The advent of the atomic age has brought many new wonders to medicine, but it has also brought many new problems and fears. Atomic energy can be a wonderful instrument for good, or it can produce fission and fusion for the destruction of civilization. Because of this, radiation and isotope therapy in skin diseases is being critically regarded. Ths paper will review many of our treatments and discuss the advances, the trends, and the future

outlook. The use of ultrasoft versus low-voltage radiation therapy, radioactive isotopes, such as thorium-X radiophosphorus and the beta rays, and the problem of protection will be discussed.

11:10 a.m.

Business Meeting

11:25 a.m.

Research Studies of Psoriasis

Walter B. Shelley, M.D., Professor of Dermatology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

A review will be given of the basic biology of psoriasis with special emphasis on the critical determinant factors. The newer findings on the chemistry of psoriasis will be reviewed, and an attempt made to assess their significance from the clinical standpoint.

Finally, the speaker's results in the treatment of psoriasis with the new steroid, triamcinolone, will be reviewed.

12:30 p.m.

Luncheon—Section on Dermatology

Bakewell Room, 1st floor

GENERAL PRACTICE

Malcolm M. Dunham, M.D., Chairman, Woodbridge

Robert E. Verdon, M.D., Secretary, Cliffside Park

Viking Room, 13th floor

10:00 a.m.

The Doctor's Personality in Patient Care

Henry A. Davidson, M.D., Superintendent, Essex County Hospital, Cedar Grove

The doctor's personality is a factor in the kind of medical care he gives. This is true even if the patient has organic disease. Emotions influence organic disease by affecting vascularity, tonus and secretions. And the physician's personality influences the patient's emotions. Some doctors are temperamentally unwilling to make decisions and thus throw this burden on the patient. Others are, by temperament, very "executive" and deprive the patient of any sense of participation. Thus the physician's personality exercises an effect on the patient's welfare. The detached physician lacks the spark which effective human relation demands. The over-involved physician invests too much emotion in the patient for anyone's good.

10:30 a.m.

The General Practitioner and the Psychiatric Service of a General Hospital

Harvey J. Tompkins, M.D., Director, Reiss Mental Health Pavilion, St. Vincent's Hospital, New York, N. Y.

The history of the development of facilities for psychiatric treatment in general hospitals will be given including the influences which have molded our present concepts regarding the different roles of such a service. The integration of psychiatric services with other activities of the hospital will be discussed and also the place of psychiatric services of general hospitals among the other health resources in the community. The relationships of the private practitioner with these hospital services in the preventive treatment and rehabilitative phases of psychiatric illness will be stressed.

11:00 a.m.

Business Meeting

11:10 a.m.

Management of the Dependent Patient

John Donnelly, M.D., Medical Director, Institute of Living, Hartford, Conn.

When a patient calls a doctor for professional assistance, there are many psychologic implications, some of which are taken for granted by the doctor and many of which are not recognized by him. The practitioner is usually endowed by the patient with magical qualities, an aspect of the relationship which is frequently outside the awareness of both patient and physician. In some ways this contributes to many of the hostile reactions of patients to the failure or limitations of treatment.

Whether the disorder of the patient is a physical or emotional one, the initial basis of treatment is the dependency of the patient. Many patients are able to maintain their position in the community and to function reasonably satisfactorily when these dependency needs are gratified. Sometimes the demands on the doctor are much greater than he can tolerate and it is important that the nature of the relationship be recognized. Ways of handling these problems will be discussed.

11:40 a.m.

General Discussion

12:30 p.m.

Luncheon—New Jersey Academy of General Practice

Parlor A, Chalfonte

PEDIATRICS

JOSEPH F. RAFFETTO, M.D., Chairman, Asbury Park
MILTON M. WILLNER, M.D., Secretary, Newark

Roberts Room, Chalfonte

10:00 a.m.

Recent Developments in Pediatric Endocrinology
Herbert S. Kupperman, M.D., Associate Professor of Medicine, New York University Post-Graduate Medical School, New York, N. Y.

The problem of thyroid abnormalities in children will be considered with emphasis on the newer concepts concerned with the hypometabolic syndrome. The modern treatment of hypogonadism in the male child will be discussed. The proper approach to the treatment of intersex and the management of the child with indifferent external genitalia will be presented in detail, discussing the use of the chromatin pattern technic for sex determination. The value of the newer hormonal agents in the treatment of pediatric endocrinopathies by the pediatrician will be outlined and emphasized.

10:30 a.m.

The Role of Steroids in the Treatment of Childhood Tuberculosis
Arthur Heyman, M.D., Attending in Pediatrics, Newark Beth Israel Hospital, Newark
Co-Author: Edward Levitzky, M.D., Newark
Discussor: Horace O. Bell, M.D., Belleville

For the past two years on the Children's Tuberculosis Service of the Essex County Hospital at Belleville, we have been studying the effects of the administration of Meticorten® in conjunction with antituberculous drugs. Five types of tuberculous lesions in infancy and childhood have been investigated: (1) Meningitis, (2) Acute miliary, (3) Pleural effusion, (4) Progressive primary pulmonary and (5) Endobronchial. Cases selected for treatment with this combined therapy were either those with grave symptoms and prognosis or those which usually respond poorly to specific antituberculous drugs alone. The use of steroids has resulted in prompt defervescence, abatement of toxicity, increased appetite and weight gain, and significant improvement in x-ray findings particularly in the exudative elements. The overall results encourage continued trial of this therapeutic regimen.

11:00 a.m.

Business Meeting

11:15 a.m.

The Problem of Staphylococcal Infections in the Hospital Nursery
Lewis L. Coriell, M.D., Medical Director, Camden Municipal Hospital, Camden
Discussor: Thomas F. X. Lenihan, M.D., Ridgewood

The current problems presented by antibiotic resistant staphylococci will be reviewed briefly, and correlated with the problems presented in the pre-antibiotic era. Diagnostic procedures will be reviewed and the recommended procedures for prevention and control of Staphylococcus infections in the hospital and nursery will be presented.

11:45 a.m.

Hemolytic Diseases in Children

Carl H. Smith, M.D., Professor of Clinical Pediatrics, Cornell University Medical College, New York, N. Y.

Discussor: Herbert W. Engel, M.D., Long Branch

The hemolytic syndromes in infancy and childhood have felt the impact of newly developed researches and concepts. Those to be discussed include enzyme studies in relation to the metabolism of the red cell and in the conversion of indirect to direct bilirubin, the use of paper electrophoresis in characterizing an expanding group of hereditary hemoglobinopathies, and the clinical application of red cell tagging with radioactive chromium in the investigation of hemolytic states. The latter technic permits accurate measurements of the rates of red cell destruction and production in the various hemolytic states and of the survival of transfused donor cells in the anemic patient. In severe Cooley's anemia studies of the survival of transfused blood in the patient serve as a guide to splenectomy. The increased susceptibility to infection in the splenectomized child emphasizes the need for establishing exact criteria for this procedure.

PREVENTIVE MEDICINE

JOHN M. KIMMICH, M.D., Chairman, Camden
BENJAMIN F. LEE, M.D., Secretary, Camden

Mandarin Room, 13th floor

10:00 a.m.

Medical Case Finding

Lemuel C. McGee, M.D., Wilmington, Del.; Member, Council on Industrial Health, American Medical Association; Medical Director, Hercules Powder Company

General Discussion

Case-finding is the active search for instances of disease and disability in asymptomatic as well as in more advanced stages. Its bases are the assumptions that "early" disease is more likely to be pathologically "early," and that "early" disease

is more amenable to control. Its goal is the halting of progression of disease, the prevention of complications and sequelae.

Experience in the use of case finding technics point up both values and limitations. Examples will be presented showing some findings from periodic examinations given by physicians to industrial workers, and reporting findings from a "screening" procedure—a chest x-ray survey.

10:30 a.m.

Clinical Problems in an Industrial Health Service

David H. Goldstein, M.D., Professor of Industrial Medicine, New York University Post-Graduate Medical School; Medical Director, New York Times, New York, N. Y.

General Discussion

The results of an experience of immunization against Asian Strain Influenza in an industrial population of approximately 5,000 people will be presented. The attack rates in the immunized and non-immunized groups were not significantly different. However, a significant difference in time lost in the immunized and non-immunized groups was noted. In addition, there was a significant difference in the frequency of complications in the two groups.

11:00 a.m.

Business Meeting

11:10 a.m.

What the Practicing Physician Needs to Know About Clinical Toxicology

Robert E. Eckardt, M.D., Linden; Vice-President, Industrial Medical Association

General Discussion

Several general principles are helpful to the practicing physician in arriving at the proper diagnosis in cases that involve clinical toxicology. The most important information the physician needs to know is what the working environment of the patient is like. Other factors include knowledge of the general housekeeping of the industrial plant involved, the general level of personal hygiene, predictions of, and pertinent but not misleading data on, toxic action. Finally, the practicing physician should know where he can turn for advice when he suspects toxic reactions in patients.

11:40 a.m.

Medical Practice with Employed People

John M. Wetherhold, M.D., Medical Director, E. I. duPont de Nemours & Co., Chambers Works Hospital, Deepwater

General Discussion

Chemical cyanosis in our highly industrialized State is discussed for its value to general practitioners as well as specialists.

Normal and cyanotic conditions are reviewed from clinical and chemistry standpoints. Particular emphasis is placed on the etiologic role of aromatic nitro and amino compounds. This includes physiologic discussion and both general and specific measures for prevention, recognition, and treatment. Time necessarily confines the depth of this detailed subject.

RADIOLOGY

Jules H. Bromberg, M.D., Chairman, Newark

Stephen B. Dewing, M.D., Secretary, Flemington

Blue Room, Chalfonte

10:00 a.m.

Today's Problems in Tuberculosis Control

William J. Dougherty, M.D., Metropolitan District Health Officer, New Jersey State Department of Health, Newark

Practical problems exist in the control of tuberculosis in New Jersey. Forty per cent of deaths due to tuberculosis in the state occur in our major cities. The incidence rate of newly reported active disease remains stable at approximately 40 per 100,000 persons each year. Approximately 80 to 90 per cent of newly discovered cases have moderate to far advanced lesions.

New cases of tuberculosis are incompletely reported. When newly discovered cases are not reported, their contacts cannot be determined and cannot be examined; therefore, source cases are not found and brought to medical care and the spread of disease is not interrupted.

Admission x-ray case finding programs in selected hospitals have revealed as high as 12 per cent of persons who require further examination of pulmonary abnormalities. Over 132,000 persons were screened in community surveys sponsored by the State Health Department in 1957. New cases of active disease are found in these surveys at a rate of 6 per 10,000 persons examined.

Selective tuberculosis case finding programs are indicated in New Jersey. In urban centers having high tuberculosis incidence, mass chest x-ray surveys are indicated. Increased emphasis on hospital admission x-ray examination programs is indicated.

Tuberculin testing of children and effective follow-up of positive reactors and their families is a potent epidemiologic tool that is recommended for use throughout New Jersey. Tuberculin testing of young adults up to age 25 constitutes an area that may be properly studied in tuberculosis control.

10:30 a.m.

Treatment of 390 Cases of Hyperthyroidism with Radioactive Iodine

Louis J. Levinson, M.D., Director, Radioisotope Department, Newark Beth Israel Hospital, Newark

This paper is a review of the findings and results obtained in 390 patients who were referred to the Radioisotope Department of the Newark Beth Israel Hospital, for the treatment of hyperthyroidism between 1951 and 1956.

All of these patients were treated with radioactive iodine (I 131). Two-hundred seventy patients in this series had toxic diffuse goiter, 44 toxic nodular goiter and 69 had recurrent post surgical hyperthyroidism.

All cases were observed for at least one year after I 131 therapy. Three tables are included showing age distribution, follow-up results and causes of death. Also illustrations, 2 x 2 inch lantern slides.

10:50 a.m.

Business Meeting

11:00 a.m.

Diagnostic Value of Radiologic Studies in Liver Disease

Harry J. Perlberg, M.D., Professor of Radiology, Seton Hall College of Medicine and Dentistry, Jersey City

Co-Authors: Carroll M. Leevy, M.D., and Harry J. Perlberg, Jr., M.D., Jersey City

Radiologic technics are important in evaluating hepatic disease, when combined with clinical biochemical, physiologic and histologic studies. Amplification of standard technics aids in estimating hepatic size and shape, and in detecting esophageal varices. Cholecystography and intravenous cholangiography are useful in evaluating hepatic functional reserve, and have demonstrated unsuspected gallstones in established liver disease. Intravenous, percutaneous and operative cholangiography help differentiate intrahepatic and extrahepatic biliary obstruction. Vascular contrast studies (percutaneous splenoportography, transhepatic venography, operative portal venography and hepatophlebography) aid in identifying space-occupying lesions of the liver, and serve as a preoperative guide, and permit evaluation of treatment results in portal hypertension.

11:20 a.m.

Experiences with Unusual Biliary Tract Pathology

William L. Palazzo, M.D., Teaneck

Most physicians have ample experience in their daily practice with the more common disorders of the biliary tract. These include dysfunction of the gall bladder, and opaque and non-opaque calculi. There are a number of less common disorders which are seen occasionally and sometimes rarely. Calcified gall bladder is the result of chronic long standing gall bladder. Milk of calcium bile is occasionally seen and is probably related to disorganized function. Air cholecystitis is a rather rare form of gall bladder disease. The visualization of Rokitansky-Aschoff sinuses in a functioning gall bladder probably represents the result of a chronic cholecystitis. The presence of calculi in a markedly dilated common bile duct, associated with relatively normal function of the gall bladder is a rare occurrence. Fistulas between gall bladder and intestinal tract are an uncommon occurrence.

12:30 p.m.

Luncheon—Section on Radiology

Zodiac B, Chalfonte

RHEUMATISM

William D. Kimler, M.D., Chairman, Haddon Heights

Clarence B. Whims, M.D., Secretary, Ventnor

Rutland Room, 1st floor

10:00 a.m.

Symposium on Rheumatoid Arthritis of the Foot

Medical Aspect

L. Maxwell Lockie, M.D., Professor of Therapeutics, University of Buffalo School of Medicine, Buffalo, N. Y.

Co-Author: Harold M. Robins, M.D., Buffalo, N. Y.

Discussor: Peter J. Warter, M.D., Trenton

To treat arthritis involving the feet, it is necessary to diagnose the type of arthritis. Three principal forms of arthritis involve the feet: rheumatoid arthritis, osteoarthritis, and gouty arthritis. The diagnosis of each will be discussed in detail, including useful salient features by which the correct diagnosis may be determined quickly.

An outline of treatment suitable for each of the different forms of arthritis will be given.

Rehabilitation

Henry H. Kessler, M.D., Newark; Medical Director, Kessler Institute for Rehabilitation, West Orange

This paper deals with a five-point plan for management of the arthritic foot:

1. Differential diagnosis from allied disorders.
2. Systemic treatment of the underlying arthritis.
3. The employment of all physical therapy measures with proper supports and shoes.
4. The systematic employment of appropriate exercises.
5. The use of surgical measures to restore anatomic form and reduce functional impairment.

Discussor: Daniel E. Kavanaugh, M.D., Newark

Orthopedic Devices for the Shoe—The Problem as Seen by the Orthopedic Appliance Specialist

Mr. William Locasio, Orthopedic Appliance Specialist, Hospital for Special Surgery, New York, N. Y.

Discussor: William G. Kuhn, Jr., M.D., New Brunswick

A properly fitted and balanced shoe contributes a great deal to the comfort of arthritic patients. This indispensable balance can be achieved only after careful consideration of the type last which will afford the most comfort yet bring the entire foot into weight-bearing position. After the proper shoe size is determined it is then necessary to consider the various corrective shoe measures which singly or in combination will properly align the patient's foot. In an advanced arthritic condition where the foot is stabilized a latex mould is used as a filler.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Rheumatism
Navajo Room, 15th floor

UROLOGY

Arthur T. Willetts, M.D., Chairman, Summit
Ralph J. Veenema, M.D., Secretary, Ridgewood

Zodiac A, Chalfonte

10:00 a.m.

Symposium on Experience with Various Methods of Urinary Diversion

Willet F. Whitmore, Jr., M.D., Attending Surgeon, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

This is a review of experience on the Urologic Service of Memorial Center with cutaneous ureterostomy, Coffey I ureterosigmoidostomy, Leadbetter ureterosigmoidostomy and ileal bladder construction in a total of 350 patients who had urinary diversion during the course of treatment of a variety of pelvic cancers. The various methods of urinary diversion are compared with respect to operative mortality and morbidity, pyelographic results, and incidence of pyelonephritis and electrolyte imbalance. On the basis of this experience the present policy with regard to urinary diversion is outlined.

George T. Whittle, M.D., Asbury Park; Associate Attending Urologist, Fitkin Memorial Hospital, Neptune
Discussor: C. Byron Blaisdell, M.D., Asbury Park

This paper will be a discussion of the recent experience with twenty-three varied urinary diversionary procedures during the past fourteen months in Monmouth County. Ureterosigmoid anastomosis and ileal conduit procedures will be compared and representative slides of pre- and postoperative pyelograms will be shown. The relative merits of the isolated ileal conduit procedures will be stressed, as these have proved to be a very effective, safe, simple versatile method of diversion with reasonable patient acceptance.

11:00 a.m.

Some New Urologic Aspects of Hypertension

John J. Murphy, M.D., Assistant Professor of Urology, University of Pennsylvania School of Medicine, Philadelphia, Pa.
Discussor: Ralph C. Yeaw, M.D., Paterson

Advances in the clinical recognition of certain hypertensive states, diagnostic methods, and reparative surgery have opened new vistas for management of this troublesome disease. Recognition of the patient who is most likely to benefit from complete investigation is most important. Intelligent application of refined diagnostic procedures will lead to the discovery of correctable lesions in a considerable number of patients, who may then benefit by modern surgical management.

11:30 a.m.

The Relationships of Present Day Physicians and Society

Samuel Lerman, M.D., Attending Urologist, Elizabeth General Hospital and Dispensary, Elizabeth

The enormously complex relationship of doctor-patient-insurance-consultant is explored in general. Some possible remedies are suggested to slow down and perhaps reverse the present trend of mutually increasing mistrust.

11:50 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Urology
Rowsley Room, 1st floor

MEDICINE

Louis A. Principato, M.D., Chairman, Camden
Henry L. Drezner, M.D., Secretary, Trenton

Viking Room, 13th floor

2:00 p.m.

Rheumatic Fever Prevention—Results of a Two-Year School Program
Thomas M. Kain, Jr., M.D., Attending in Medicine, Cooper Hospital, Camden
Discussor: Walter A. Crist, M.D., Camden

Introduction to subject of hemolytic streptococcus infections of the upper respiratory tract in its relationship to rheumatic fever. The problem of detection of the Beta Hemolytic Streptococcus. The technic used in the program to identify this Streptococcus. The description of the Parkside School Program in 1954-1956, including culturing of asymptomatic children for carriers and home culturing for contacts. Presentation of the results of this two-year program in the form of lantern slides. Summary and conclusion, showing a short, silent 8 mm. movie, taken by the P.T.A. of Parkside School showing the program in operation.

2:30 p.m.

Treatment of Hypertension
Garfield G. Duncan, M.D., Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa.
Discussor: William A. Halbeisen, M.D., Haddonfield

The value of establishing a severity index with which to compare subsequent surveys is stressed. The treatments for the various degrees of essential hypertension are outlined with particular reference to chlorothiazide (Diuril®) in therapy of today. The reduced but important place that sympathectomy retains is dealt with.

3:00 p.m.

Business Meeting

3:15 p.m.

Practical Considerations in the Use of Anticoagulant Therapy in Different Manifestations of Coronary Disease
Joseph B. Vander Veer, M.D., Associate Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.
Discussor: Edwin N. Murray, M.D., Camden

Anticoagulant drugs have proved to be of value in the treatment of several of the manifestations of coronary disease. The discussion will include therapeutic measures for active coronary disease with pre-infarction angina and the indications for anticoagulant therapy in the management of the acute attack of myocardial infarction. Newer technics for the use of concentrated heparin will be stressed. The results of long term oral anticoagulant therapy in the prevention of recurrent infarction will be considered.

3:45 p.m.

The Patho-Physiologic Aspects of Pancreatic Disease
William J. Snape, M.D., Chief, Department of Gastroenterology, Cooper Hospital, Camden
Discussor: Reuben L. Sharp, M.D., Camden

It is common clinical experience that pancreatic disease presents a diagnostic challenge. The reasons for this will be briefly reviewed. The basic mechanism for the production of the various signs and symptoms will be discussed along with the applied physiology of clinical tests of pancreatic function.

ALLERGY

Francis A. Pflum, M.D., Chairman, Asbury Park
Frank L. Rosen, M.D., Secretary, Newark

Mandarin Room, 13th floor

9:30 a.m.

Hints for the Management of Atopic Dermatitis
Arlington Bensel, M.D., Asbury Park; Attending Dermatologist, Fitkin Memorial Hospital, Neptune
General Discussion

The various approaches to the management of atopic dermatitis are outlined and evaluated. Medical management, allergic factors, the place for topical and parenteral corticosteroids and psychotherapy are presented. The importance of definite diagnosis and the fine points to help establish the diagnosis are discussed. Treatment programs are outlined—directed toward keeping the difficult cases of atopic dermatitis under control.

10:00 a.m.

Clinical Review of Eighty-Five Cases of Penicillin Sensitivity
William I. Weiss, M.D., Newark; Attending in Internal Medicine and Allergy, Veterans Administration Hospital, East Orange
General Discussion

Reactions to penicillin run the gamut of known drug reactions, from simple skin rashes through visceral lesions to sudden anaphylactic death. Only a small percentage of sensitive patients will demonstrate positive skin tests and even test doses may

precipitate serious reactions. Eighty-five penicillin sensitive patients showed a predominance of urticarial and eczematoid type reactions. Most had prior exposures to penicillin, although many reacted to the first dose. Associated allergic diseases appeared in a significant percentage.

The warning is resounded to avoid penicillin where possible, especially in allergic patients. A careful history is mandatory and cautious skin testing advised. Whenever possible, use the oral route of administration.

10:30 a.m.

Management of Lymphoid Hyperplasia in Allergic Children

William L. Wood, M.D., Red Bank; Attending Otolaryngologist, Fitkin Memorial Hospital, Neptune

General Discussion

The problem of adeno-tonsillectomy in the allergic child is associated with much difference of opinion. This paper suggests a causal relationship of infection to the allergic diseases and shows why the lymphoid tissue of Waldeyer's ring (as a focus of chronic infection) plays an important role in the development of bacterial allergy. Since there is increasing resistance of bacteria to antibiotics, the paper stresses the importance of complete surgical removal of lymphoid tissue of the pharynx, hypopharynx and naso-pharynx.

Because of the tendency of the allergic child to lymphoid hyperplasia and regeneration even after the most adequate and complete surgery, the author recommends x-ray irradiation following surgery to control postoperative regeneration.

11:00 a.m.

Repository Ragweed Therapy

John H. Mitchell, M.D., Clinical Professor, Department of Medicine, and Head of Division of Allergy, Ohio State University, Columbus, Ohio

General Discussion

Over the last twenty years repeated efforts have been made to simplify the immunization treatment of pollen hay fever and asthma. During the past ten years Mary Loveless, M.D. has developed a slowly absorbing mineral oil-ragweed emulsion which has made possible the administration of the entire season's immunizing dose in a single afternoon. The total dose is predicated upon quantitative conjunctival testing with serial dilutions of aqueous ragweed extract. The mineral oil-ragweed emulsion contains 1,000 PNU of ragweed antigen to each 0.1 cc. of emulsion. The total dose is calculated as 5,000 units for the most sensitive, 7,500 units for moderately sensitive and 10,000 units for the mildly sensitive. Individual doses are injected subcutaneously in amounts of 0.25 cc. at thirty minute intervals in early June since it requires about two months for maximum immunity to develop. Experience with this method in thirty cases during the 1957 season will be reported.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Allergy and New Jersey Allergy Society

Bakewell Room, 1st floor

CHEST DISEASES

Arthur Bernstein, M.D., Chairman, Newark

A. Albert Carabelli, M.D., Secretary, Trenton

Viking Room, 13th floor

10:00 a.m.

Endoscopic Therapy of Lung Abscess

A. Albert Carabelli, M.D., Attending in Thoracic Medicine, St. Francis Hospital, Trenton

This paper is concerned with the treatment of a series of patients suffering from acute lung abscess. The therapy includes bronchoscopic instillation of oleaginous penicillin directly into the abscess cavity or area. The special instruments used for this technic as well as an upper lobe bronchoscopic which permits instillation into upper lobe abscess are described. By this method, toxic symptoms subside within a few days and there is restoration to normal of the parenchyma. No patient in the series so treated has required surgery.

10:20 a.m.

Fluoroscopic Determination of Pulmonary Stenosis—A New Sign

Henry Green, M.D., Attending in Medicine, St. Michael's Hospital, Newark

In a group of proved valvular pulmonic stenosis without over-riding of the aorta a significant number of patients exhibited appreciable pulsation of the left pulmonary artery in the presence of a "quiet" right pulmonary artery. The finding is presented as a reliable sign, when present, of pulmonic stenosis.

10:35 a.m.

Familial Pulmonic Stenosis and Deaf Mutism—Clinical and Genetic Considerations

Sanford M. Lewis, M.D., Assistant in Medicine, Newark Beth Israel Hospital, Newark

Co-Authors: Lawrence Gilbert M.D., Newark; David Biber, M.D., Union; and Benjamin B. Sonnenblick, Ph.D., Newark

The study describes a unique family group in which the mother and three children exhibit clinical pulmonary stenosis, and two of the three children manifest concomitant deaf-mutism. The possible role of extrinsic etiologic factors is discussed, and their apparent absence emphasized. A genetic mechanism is postulated in which a dominant gene contributed by the mother is determinative for the cardiac lesion, and a recessive gene transmitted by both parents is responsible for the manifestation, in homozygous offspring, of the sensory-motor abnormality.

(It might be added that a search of the literature has failed to identify a single previous example of this combination of congenital lesions in so many members of the family group.)

10:55 a.m.

Discussion on Above Papers

11:10 a.m.

Evaluation of Pleural Biopsy

William B. Abrams, M.D., Newark, Ward Physician, Veterans Administration Hospital, East Orange

Co-Author: Maurice J. Small, M.D., East Orange

Since 1953, 29 pleural biopsies by open thoracotomy have been done at the Veterans Administration Hospital, East Orange, in cases of pleurisy with effusion, the etiology of which could not be established by other means. Of these, 22 were ultimately diagnosed as tuberculous in origin, and these cases form the basis of this report. The final diagnoses were based on the biopsy reports, clinical course, response to therapy, the presence of tuberculosis elsewhere, skin test conversion, and, unusually, the identification of tubercle bacilli. Since the procedure was done only in cases when the etiology was in doubt after thorough study, they represent a selected group. Nevertheless several observations may be made. In approximately two-thirds of the cases histologic studies showed the presence of epithelioid giant cell tubercles. Most of these also showed the caseous-necrosis characteristic of tuberculosis. The extent and character of the pleural involvement in these selected cases cast further doubts on the validity of previously held concepts of the pathogenesis of tuberculous pleurisy with effusion. From the practical point of view, this experience indicates pleural biopsy is a safe and valuable procedure. Specific cases will be presented to demonstrate its superiority over needle biopsy and cytologic studies of pleural fluid.

11:30 a.m.

Use of Meticorten in Chronic Pulmonary Tuberculosis

Paul K. Bornstein, M.D., Asbury Park; Attending in Medicine, Fitkin Memorial Hospital, Neptune

Co-Authors: Israel G. Epstein, M.D., Brooklyn, N. Y., and G. Nair, M.D.

A group of 22 patients with chronic, active, pulmonary tuberculosis with emphysema was treated with anti-microbial drugs and prednisone for an 8 to 12 month period. Twenty-two controls were followed simultaneously. These were not terminal cases, but so-called "good chronics." Several untoward effects were noted primarily in diabetes in three patients and cardiac decompensation in four others. No significant roentgen deterioration was observed. Ventilatory function studies were moderately to markedly improved. One unexpected and intriguing finding was the complete absence of hemoptysis in the prednisone treated group of which 10 had a previous history of repeated hemoptysis.

A discussion of the pathologic physiology is offered.

11:50 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Chest Diseases and New Jersey Chapter, American College of Chest Physicians

Navajo Room, 15th floor

GASTROENTEROLOGY AND PROCTOLOGY

Leonard Troast, M.D., Chairman, Jersey City

Irving G. Larkey, M.D., Secretary, Newark

Blue Room, Chalfonte

9:30 a.m.

Value of Postoperative Gastrointestinal Roentgenography

Herbert Greenfield, M.D., Newark; Attending, Section of Gastroenterology, Clara Maass Memorial Hospital, Belleville

Discussor: Joel Feldman, M.D., Red Bank

Gastric and colonic surgery can produce both moderate to marked postoperative x-ray changes. These defects are difficult to interpret roentgenologically from benign lesions to malignant growths. Early postoperative x-ray studies following colonic

and gastric surgery are strongly advised to serve as controls for future follow-ups.

Several cases are presented illustrating these surgical defects. Their value as controls with their x-ray changes are defined.

10:00 a.m.

Lesions of the Mouth and Lips Diagnostic or Suggestive of Systemic Disease

Harold J. Jeghers, M.D., Professor and Director, Department of Medicine, Seton Hall College of Medicine and Dentistry, Jersey City

Discussor: Vito F. Cangemi, M.D., Jersey City

Many systemic diseases produce changes in the oral cavity and the lips which can be readily detected on clinical inspection and, at times, by palpation with a gloved hand. This presentation illustrates some instances in which the mouth lesion is distinctive enough to suggest its systemic cause. Colored lantern slides show gum changes, cheilosis and angular stomatitis, acute macroglossia, chronic macroglossia, glossitis, oral pigmentation, and vesicular mucosal lesions.

10:30 a.m.

Diagnosis and Management of Functional Gastrointestinal Disorders

Moses Paulson, M.D., Associate Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, Md.

Discussor: Andrew J. V. Klein, M.D., East Orange

Functional derangements of the digestive tract —possibly next to the common cold and minor injuries—are the most frequent causes for complaints from which relief is sought. At the same time the persisting and frequently recurring manifestations are among the most difficult to manage. This presentation concerns the more common disturbances and the manner in which they may be diagnosed.

Therapy involves: a study satisfying the patient that organic disease has been sought for and, if present, adequately evaluated; giving insight into the manner in which he responds to interpersonal relations and life's situations; and the influence of these upon and the nature of the altered physiology accounting for complaints. These are coupled with common sense suggestions as to approaches and attitudes plus a simple explanation of the pharmacologic action and the intended effects of drugs as well as the purely palliative position of both drugs and diet. Thus, emphasis is placed upon the person rather than upon the immediate cause for complaints (as irritable colon).

Diagrammatic schemata used with patients to clarify and simplify management will be presented.

11:00 a.m.

Business Meeting

11:10 a.m.

Growth Patterns in Adenomatous Disease of the Rectum and Colon

Ralph E. L. Hertz, M.D., Assistant Attending Surgeon, Memorial Hospital, New York, N. Y.

Co-Author: F. Shipkey, M.D., New York, N. Y.

Discussor: Urban R. Finnerty, M.D., Montclair

Guest Discussor: Isias Schor, M.D., Assistant Physician, Institute of Gastroenterology, Buenos Aires, Argentina

A preliminary report is given of observations upon approximately 400 patients with early adenomatous disease of the rectum and colon followed by a solitary observer in the Strang Cancer Detection Clinic at the Memorial Center for Cancer and Allied Diseases, New York City.

The characteristics of growth patterns are traced in terms of chronology and gross and microscopic anatomy from the phase of early hyperplasia through early malignancy. The observations made upon this group are related to the more extensive total experience of the Rectal and Colon Service and the Strang Detection Clinic at the Memorial Center.

METABOLISM

William Levison, M.D., Chairman, Newark
J. John Kristal, M.D., Secretary, Hackensack

Rutland Room, 1st floor

10:00 a.m.

Renal Changes in Hypokalemia

Donald E. Brown, M.D., Director of Laboratories, Hackensack Hospital, Hackensack

The kidneys in hypokalemia show frequent physiologic and occasional anatomic changes. The physiologic changes are characterized by excess excretion of hydrogen ions, polyuria and hyposthenuria. The anatomic changes are characterized by vacuolization of the tubules. The pathogenesis, inter-relationships, and clinical significance of these changes are discussed.

10:20 a.m.

The Treatment of Hyperthyroidism with Radioactive Iodine

Solomon Silver, M.D., Chief, Thyroid Clinic, Mount Sinai Hospital, New York, N. Y.

The speaker has treated or supervised the treatment with I-131 of some 3,000 patients with hyperthyroidism since 1947.

Over 1,600 of these patients have had their pretreatment, treatment and follow-up data coded and placed on I.B.M. cards for statistical evaluation.

The results, indications and contraindications for treatment will be discussed on the basis of the speaker's experience.

10:40 a.m.

Practical Aspects of Iron Metabolism

Murray Nussbaum, M.D., Instructor in Medicine, Seton Hall College of Medicine and Dentistry, Jersey City

The metabolism of iron in man must be considered from several physiologic modalities as a foundation for proper diagnosis and treatment in iron deficiency states. These include excretion, absorption, transport, storage and incorporation into the erythrocyte.

The estimation of iron stores by examination of the bone marrow aspirate, is a simple and exact method of differentiating iron deficiency states from other hypochromic anemias, and for determining the necessity for supplemental iron.

Nineteen of thirty-five cases of chronic iron deficiency were treated with an intramuscular iron-dextran preparation for periods ranging from 5 to 70 weeks, and was effective in maintaining normal hemoglobin levels and decreasing the need for frequent transfusions.

11:00 a.m.

The Present Day Treatment of Diabetes Mellitus Including the Oral Substances

Edward Tolstoi, M.D., Associate Professor of Clinical Medicine, Cornell University Medical College, New York, N. Y.

When the first slow acting insulin—protamine zinc insulin—became available about 20 years ago, we noted certain unorthodox clinical responses when this preparation was used. The patient gained weight, and had no symptoms of diabetes even though a glycosuria was present throughout the day. Since these findings were not in accord with the accepted ideas and teaching of the times, metabolic experiments were undertaken with the hope of elucidating these findings. It was this study which was the basis for the concept of a new approach called the "Clinical Technique." This method emphasized more the well being and physical condition of the patient than it did a normal fasting blood sugar and a sugar free urine. The latter were, and still are the major criteria of satisfactory control by the "Chemical Technique." Thus, after a period of experimental and clinical experience with the "Clinical Technique," there arose two schools of thought—one, the orthodox or classical, maintaining that a normal chemical balance was the *sine qua non* of good therapy; the other disregarded the blood and urine findings and rather emphasized the status of the patient.

This presentation will discuss the treatment of diabetes mellitus, using the clinical criteria as guides and also present the author's rich experience during the past 20 years. Sufficient time has elapsed to evaluate the results, in the light of the late findings in diabetes, namely, diffuse vascular disease. Data will be presented and conclusions drawn.

A brief discussion will also be presented on the present status of the oral hypoglycemic compounds.

11:20 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Metabolism and Medical Members, New Jersey Diabetes Association
Rowsley Room, 1st floor

NEUROPSYCHIATRY

Charles Englander, M.D., Chairman, Newark
George H. Lussier, M.D., Secretary, Farmingdale

West Room, 13th floor

10:00 a.m.

Cerebral Vasospasm Associated with Intracranial Aneurysms

J. Lawrence Pool, M.D., Professor of Neurologic Surgery, Columbia University College of Physicians and Surgeons, New York, N. Y.

Discussor: Thomas S. P. Fitch, M.D., Plainfield

Spasm of the larger arteries at the base of the brain is frequently observed on arteriogram x-rays after recent hemorrhage from a ruptured intracranial aneurysm. Cerebral vasospasm of this kind is often progressive and may then lead to permanent brain damage or even to fatal brain swelling. This is one important reason why ruptured intracranial aneurysms should be *promptly* operated upon with direct surgical obliteration of the aneurysm within the head. A relatively new and promising technic for such aneurysm surgery 1 to 12 days after fresh subarachnoid hemorrhage is demonstrated with color photographs.

10:30 a.m.

The Psychiatric Aspect of Medical Practice

Sandor Rado, M.D., Professor of Psychiatry and Director of the School of Graduate Psychiatry, State University of New York Down State Medical Center, New York, N. Y.

Discussor: Evelyn P. Ivey, M.D., Morristown

Impact of physical disease upon the patient's emotional security; his self-confidence and significant emotional relationships. Overt and hidden

aspects of the patient's emotional response to his physician: automatic recrudescence of the behavior pattern of infantile dependence and magical thought; the patient's resentment of the physician's failure to achieve magical cure. By assuaging the patient's emergency emotions and reinterpreting his illness as a challenge, the physician seeks to overcome the patient's dependency craving and to move him toward realistic collaboration. Patient's gainful exploitation of his illness. Emotional preparation for a healthy life performance.

11:00 a.m.

Business Meeting

11:15 a.m.

Electroencephalography in Behavior Disorders of Childhood

Ira S. Ross, M.D., South Orange; Associate in Neuropsychiatry, The Presbyterian Hospital, Newark

Discussor: Berthold E. Schwarz, M.D., Montclair

The kind of information that is obtained by the electroencephalogram will be described. An attempt will be made to indicate how this information helps the over-all evaluation of the patient. Material from private practice and from the New Jersey State Diagnostic Center at Menlo Park will be used.

11:45 a.m.

Tuberculoma of the Brain Presenting a Picture of Psychosis

Hans Wassing, M.D., Consultant in Neuropsychiatry, Barnert Memorial Hospital, Paterson

Discussors: Stanley Stellar, M.D., Paterson; Jacob Churg, M.D., Teaneck

A 44-year old woman had shown signs of increasing depression for two months. Then she had a jacksonian seizure pointing to the left side of the brain. The serology of blood and spinal fluid was "four plus."

Depressive psychosis remained the presenting feature. There were no neurologic signs. Penicillin therapy had no effect.

Ventriculogram revealed a mass in the left frontal lobe.

Operation (Dr. Stellar) showed a tumor near the pole of the frontal lobe, adherent to dura and brain. This was removed and proved to be a tuberculoma. Tubercle bacilli were demonstrated in the tissue. The patient made excellent recovery.

OPHTHALMOLOGY

Samuel M. Diskan, M.D., Chairman, Atlantic City
Edward A. Atwood, M.D., Secretary, Paterson

Zodiac A, Chalfonte

10:00 a.m.

Non-Surgical Treatment of Ocular Injury

James S. Shipman, M.D., Camden; Attending Surgeon, Wills Eye Hospital, Philadelphia, Pa.

Contusions with edema, and ecchymosis of the lids and subconjunctival hemorrhages. Electric flash burns, subconjunctival hemorrhages—chemical, acid and alkali burns—also, hot metal burns. All of these treated with ice compresses, midriatics and liquid petrolatum, and antibiotics; early ice compresses; later hot compresses. Holocaine® or Pontocain® when needed for pain.

Corneal abrasions: Pontocain®, midriatics, antibiotics and sometimes cauterization with trichloracytic acid 30 per cent, pressure patch.

Hyphemia: Hospitalization, complete bed rest, no midriatics. If anything, a miotic until hemorrhage is absorbed, then homatropine, vitamin K, hykanon 1 cc. intramuscularly daily for three or four days. If hemorrhage increases and tension goes up Eight Ball Eye, paracenthesis with evaluation of the clot.

Vitreous hemorrhage: Organidin®, typhoid fever vaccine, midriatics, and hykanon, hot compresses and bed rest.

10:20 a.m.

Surgical Treatment of Ocular Injury

P. Robb McDonald, M.D., Attending Surgeon, Wills Eye Hospital, Philadelphia, Pa.

Any penetrating wound of the eye must be considered as an ophthalmologic emergency. The discussion will be concerned with: the prevention of infection, and—when surgery is indicated.

Methods for handling corneal and scleral wounds will be presented. The management of iris prolapse, lens damage, intraocular foreign bodies, *et cetera*, will be discussed.

10:50 a.m.

Plastic Surgery Following Orbital Injuries

Byron Smith, M.D., Surgeon Director, Manhattan Eye, Ear, and Throat Hospital, New York, N. Y.

Plastic surgery following orbital and ocular injuries is important because it contributes to the rehabilitation of physiologic function, anatomic restoration and psychologic equanimity. The principles of ophthalmic plastic surgery should be initiated as soon after injury as the complete post-

traumatic diagnosis is known. The presence of additional injuries and advice of other specialists, frequently influences the time and extent to which the ophthalmologist should indulge in early definitive treatment.

A detailed history of the mechanism of injury, combined with a conscientious survey of ocular function and the securing of indicated x-rays, usually, supplies the information necessary to outline the orbital treatment. If preliminary emergency suturing has been done, one should not hesitate to extricate all of the sutures and explore the depths of the wound. Gentle handling and preservation of all viable tissue fragments may mean the difference between success and failure. Systemic supportive treatment is as important in orbital wounds as it is in wounds over the rest of the body. Suturing of wounds by delayed primary closure is an effective means of treatment even as late as two weeks following injury.

Treatment of orbital fractures may be delayed as much as ten days, if necessary. Double vision and ocular deviations are treated by exercises and or occlusion until all spontaneous recovery has occurred. In general, six months is considered a reasonable interval to wait before eye muscle surgery is contemplated.

Lacrimal infection, secondary to obstruction of the lacrimal passage, should be eradicated early in the post-traumatic course. Dacryocystorhinostomy is preferable to removal of the lacrimal sac.

Lowering of the eyeball, due to malunited fractures and enophthalmos, frequently requires autogenous bone grafting. The complication of blepharoptosis, due to orbital roof injury, levator trauma and other causes, may require secondary definitive surgery after the other complications have been rectified.

Accentuation in the depth of the supratarsal sulcus is usually due to lowering of the eyeball or absorption of orbital fat. Its treatment, by insertion of a fascial graft, is delayed as a final phase in treatment.

Late treatment of fornix deformities and corneal scars is delayed until local reactions have diminished or subsided.

In the event that any deformities or residual symptoms persist after the surgeon has exercised the extent of his ingenuity, consultation by other qualified ophthalmologists is in order. Assurance in the mind of the patient that maximum improvement has been accomplished, is a means of minimizing any consternation which may delay early rehabilitation.

11:20 a.m.

Appraisal of Loss of Visual Efficiency After Ocular Injury

A. Russell Sherman, M.D., Attending Surgeon, Eye Department, Newark Eye and Ear Infirmary, Newark

Loss of visual efficiency, after ocular trauma, if it is to be comprehended by the non-medical reader, must be expressed in percentages which are derived from a schedule. Such a schedule is in common use in New Jersey. After the appraisal has been made, it is necessary to explain further the relation between the loss of efficiency and the trauma in question.

11:40 a.m.

Business Meeting

12:30 p.m.

Luncheon—New Jersey Academy of Ophthalmology and Otolaryngology

Tower Room, 13th floor

ORTHOPEDIC SURGERY

Harold T. Hansen, M.D., Chairman, South Orange
John M. Naame, M.D., Secretary, Atlantic City

Room 1344, 13th floor

10:00 a.m.

Pitfalls in the Treatment of Fractures

Jarvis M. Smith, M.D., Montclair; Attending Orthopedic Surgeon, New Jersey Orthopaedic Hospital, Orange

The author discusses the numerous errors in technic that are apt to befall the practitioner in the office and emergency room treatment of common fractures. Error in plaster cast applications, manipulations, diagnosis, and follow-up care will be highlighted. Pitfalls that might lead to legal difficulties will also be discussed. No attempt will be made to discuss cases requiring operative treatment in the hospital.

10:25 a.m.

Scoliosis—Diagnosis and Early Management

Charles I. Nadel, M.D., Attending in Orthopedics, Irvington General Hospital, Irvington

A brief resume of the historical data relating to scoliosis will be reviewed. A discussion of the etiology and pathology will be presented. Slides of illustrative cases will be shown. The importance of early recognition will be demonstrated.

10:50 a.m.

Business Meeting

11:05 a.m.

Common Causes of Gait Disturbances in Children
Bertram M. Kummel, M.D., Clinical Assistant, Morristown Memorial Hospital, Morristown

A description leading to the diagnosis of gait disturbances in children. Common disturbances encountered in children, including bow-legs, knock-knees, congenital dislocated hips, Legg-Perthe's disease, slipped femoral epiphysis, and some of the osteochondritides.

11:30 a.m.

The Amputee—The Early Management
Roy R. Ciccone, M.D., Passaic; Attending Surgeon, New Jersey Orthopaedic Hospital, Orange

The author discusses the early management of the amputee from a psychologic and physical standpoint, including the selection of the optimal site of amputation, postoperative care of the stump and some of the phases ordering and fitting the prosthesis.

12:30 p.m.

Luncheon—Section on Orthopedic Surgery and New Jersey Orthopaedic Society
Parlor A, Chalfonte

OTOLARYNGOLOGY

William Rubin, M.D., Chairman, New Brunswick
Charles E. Langgaard, M.D., Secretary, Summit

Zodiac B, Chalfonte

10:00 a.m.

Hemorrhage in Diseases of the Ear, Nose and Throat—Spontaneous and Operative
Max L. Som, M.D., Assistant Clinical Professor of Otolaryngology, New York University Post-Graduate Medical School, New York, N. Y.

The talk will include methods for the control of hemorrhage from the upper air passages including the ear, nose, throat, larynx, and esophagus. Bleeding during operations will be discussed and procedures for the arrest of hemorrhage outlined. Ligation of the major arteries supplying the source of bleeding will be illustrated. Discussion will be limited to bleeding resulting from local lesions and not resulting from general systemic diseases.

10:30 a.m.

What Surgery Can Do for Deafness
Frederick Harbert, M.D., Professor of Otorhinolaryngology and Bronchoesophagology, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Conductive deafness caused by otosclerotic fixation of the stapes can be rehabilitated by the stapes mobilization operation in about 50 per cent of suitable cases. The fenestration operation is highly successful either as a primary operation or after unsuccessful stapes surgery and should be performed more frequently.

Persistent perforations of the tympanic membrane may be closed by full thickness skin grafts (myringoplasty). Chronic mastoid and middle ear suppuration is treated by conserving all remaining middle ear structures that may be useful for sound transmission and adding grafts to construct a modified middle ear. This can be done at the time of initial mastoidectomy or later when suppuration has been controlled. These procedures are described as various forms of tympanoplasty.

11:00 a.m.

Correction of Deformities of the Nasal Tip and Septum
Lyndon A. Peer, M.D., East Orange; Clinical and Research Director of Plastic and Reconstructive Surgery, St. Barnabas Medical Center, Newark
Co-Author: John C. Walker, Jr., M.D., East Orange

With the use of lantern slides various methods of correction for displacement of the lower free border of the septal cartilage will be discussed. Also to be included in the discussion will be the management of the alar cartilage in depressed tips and the hanging columella. The author's management of reduction of the bulbous tip, the deflected septum and the necessity of turbinectomies will also be demonstrated.

11:30 a.m.

Relation of Ear, Nose, and Throat to General Medicine
Albert F. Moriconi, M.D., Attending in Otolaryngology, St. Francis Hospital, Trenton

The role of the otolaryngologist in general medicine has gradually increased during the past several years due to the fact that systemic diseases have symptomatology and signs prevalent in the ear, nose, and throat. An important example of this is the allergic patient whose primary findings may occur in the nose; infectious mononucleosis may exhibit pharyngeal involvement; measles with affections of the upper respiratory tract, *et cetera*, all point to the close relationship existing between the ear, nose, and throat, and general medicine.

12:00 noon

Business Meeting

12:30 p.m.

Luncheon—New Jersey Academy of Ophthalmology and Otolaryngology
Tower Room, 13th floor

SURGERY

12:30 p.m.

Luncheon—Section on Surgery and New Jersey Chapter, American College of Surgeons

Vernon Room, Lounge floor

JOHN L. VARRIANO, M.D., Chairman, Jersey City
JAMES H. SPENCER, M.D., Secretary, Newton

Viking Room, 13th floor

2:00 p.m.

Malignancies in Childhood

Harold W. Dargeon, M.D., Attending Pediatrician and Chief, Pediatric Service, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

Discussor: Clymont MacArthur, M.D., Newark

Neuroblastoma is one of the more frequent "solid" cancers observed in children at Memorial Hospital. There were 135 neuroblastomas among 1248 malignant tumors which occurred on the Pediatric Service. Of these 10 have survived 5 or more years and 6 have survived 2 years.

The bizarre clinical course of many neuroblastomas makes evaluation of therapeutic measures very difficult. Examples of some unexpected arrests of the disease—one apparently spontaneous—are discussed.

2:35 p.m.

Treatment of Head Injuries by the General Surgeon

William Ehrlich, M.D., Attending Neurosurgeon, Newark Beth Israel Hospital, Newark

Discussor: Gerald Winokur, M.D., Jersey City

The appalling increase in highway accidents accompanied by the large proportion of head injuries has made the latter of increasing importance to all medical practitioners. An attempt is made at a practical and concise approach to the problem in an effort to be of assistance to the practitioners everywhere who are constantly being called upon to give emergency treatment and aftercare to the victims of automobile accidents, falls and other mishaps which result in head injuries.

3:00 p.m.

Pathogenesis of the Post-Phlebitic Syndrome

William N. Barbarito, M.D., Attending Surgeon, Medical Center, Jersey City

Discussor: George F. Hewson, M.D., Newark

Anatomically the pathogenesis is focused upon skin and superficial fascia. For clarity, the term "basic anatomic physiologic unit" is coined, meaning a microscopic biologic unit. Also developed is the concept of "dynamic equilibrium" which involves the sum total of pressures and biologic responses. Various pressures are considered.

Emphasis is placed upon interstitial (tissue) pressure. Critical tissue pressure causes capillary compression and stasis. Stasis serves as a stimulus for an inflammatory response including thrombosis.

The variations in dynamic equilibrium explain the variations and non-predictableness of the sequelae of venous thrombosis.

3:25 p.m.

The Complications of Surgery in a Community Hospital

Peter J. Guthorn, M.D., Asbury Park: Acting Attending Surgeon, Monmouth Memorial Hospital, Long Branch

Co-Authors: Harold A. Kazmann, M.D., and Chang You Wu, M.D., Long Branch
Discussor: Stuart Z. Hawkes, M.D., Newark

A one-year study of complications on the general surgical service of a community hospital. Complications parallel in incidence and distribution those of larger institutions. The universal increase of infections was reflected by a rise in wound infections due to antibiotic resistant hemolytic staphylococcus aureus. A pilot study of responsible factors was initiated. Infections incurred outside the hospital were largely antibiotic-sensitive in contrast to those within the hospital.

3:50 p.m.

Business Meeting

Nominating Committee

Saturday Evening, May 17, 1958

Bakewell Room, 1st floor

8:30 p.m.

Chairman, Lewis C. Fritts, Immediate Past-President

County	*Delegate*	*Alternate*
Atlantic	David B. Allman	G. Ruffin Stamps
Bergen	G. Barton Barlow	Frederick G. Dilger
Burlington	E. Vernon Davis	R. Winfield Betts
Camden	Frank J. Hughes	James R. Eynon
Cape May	Herschel Pettit	Millard Cryder
Cumberland	Carl N. Ware	Mary Bacon
Essex	Marcus H. Greifinger	William W. Cox
Gloucester	Louis K. Collins	John J. Laurusonis
Hudson	Joseph P. Donnelly	Francis E. Rieman
Hunterdon	Lloyd A. Hamilton	Raymond J. Germain
Mercer	Karl T. Franzoni	Floyd D. Gindhart
Middlesex	Charles H. Calvin	Edward F. Klein
Monmouth	Daniel F. Featherston	Louis F. Albright
Morris	Henry O. von Deilen	Francis J. Benz
Ocean	Raymond A. Taylor	William E. Dodd
Passaic	Joseph E. Mott	Joseph R. Jehl
Salem	C. Spencer Davison	R. Louis Silverman
Somerset	George E. Barbour	Runkle F. Hegeman
Sussex	Dorsett L. Spurgeon	Robert A. Weinstein
Union	Lorrimer Armstrong	Louis S. Wegryn
Warren	Ralph M. L. Buchanan	Carl A. Maxwell

House of Delegates

President, Albert B. Kump,† M.D., Bridgeton
Secretary, Marcus H. Greifinger, M.D., Newark
Parliamentarian, Robert M. Backes, Trenton
Sergeants-at-Arms, Benjamin F. Lee, M.D., Camden
C. Spencer Davison, M.D., Salem

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Viking Room, 13th floor

SESSIONS

First Session: 2:30 p.m., Saturday Afternoon, May 17, 1958

1. Call to Order
2. Invocation
   Reverend John W. Hutchinson, The First Presbyterian Church, Bridgeton
3. Organization of the House
4. Transactions of 1957 Annual Meeting
5. Introduction of Guests and Delegates from Other States
6. Annual and Supplemental Reports
7. Resolutions
8. New Business
9. Announcements

†Deceased. A Speaker of the House will be elected to preside at all sessions.

Second Session: 4:00 p.m., Sunday Afternoon, May 18, 1958

1. Report of Nominating Committee
2. Election

Third Session: 10:00 a.m., Monday Morning, May 19, 1958

1. Reports of Reference Committees
2. Unfinished Business
3. Presentation of Fellow's Key
   To: Albert B. Kump, M.D., President
   By: Lewis C. Fritts, M.D., Immediate Past-President
4. Installation of Incoming President
   Kenneth E. Gardner, M.D., President-Elect
5. Adjournment

Reference Committees

Sunday Morning, May 18, 1958

11:00 a.m.

Reference Committee "A"

Room 1333, 13th floor

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Officer

Mary Bacon, Chairman	Cumberland County
Jacob M. Schildkraut	Mercer County
Noah Meyerson	Hudson County
Harry N. Comando	Essex County
Dorsett L. Spurgeon	Sussex County

Reference Committee "B"

Room 1344, 13th floor

Reports of the:
- Treasurer
- Finance and Budget Committee
- Publication Committee
- Medical Student Loan Fund Committee

Jesse McCall, Chairman	Sussex County
Gerard R. Gessner	Middlesex County
G. Ruffin Stamps	Atlantic County
Charles L. Cunniff	Hudson County
Frank B. Vanderbeek	Passaic County

Reference Committee "C"

Mandarin Room, 13th floor

Reports of the:
- Medical Service Administration of New Jersey
- Medical-Surgical Plan of New Jersey

F. W. Durham, Chm.	Camden County
John L. Olpp	Bergen County
John F. Kustrup	Mercer County
John J. Laurusonis	Gloucester County
Charles A. Landshof	Hudson County

Reference Committee "D"

Room 1335, 13th floor

Reports of the:
- Medical Education Committee
- Medical Defense and Insurance Committee

Special Committees on:
- Civil Defense-Disaster Control
- Physicians Placement Service
- Widows and Orphans of Medical Men
- Traffic Safety

Louis K. Collins, Chm.	Gloucester County
George E. Barbour	Somerset County
Winton H. Johnson	Bergen County
William W. Cox	Essex County
R. Louis Silverman	Salem County

Reference Committee "E"

Room 1337, 13th floor

Reports of the:
- Welfare Committee

Subcommittees on:
- Legislation
- Medical Practice
- Public Health
- Public Relations

Special Committees on:
- Cancer Control
- Chronically Ill
- Conservation of Hearing and Speech
- Conservation of Vision
- Industrial Health
- Maternal and Infant Welfare
- Mental Health
- Rehabilitation
- School Health
- Workmen's Compensation

S. Garrison, Jr., Chm.	Cumberland County
Josiah J. McCracken, Jr.	Atlantic County
Nathan S. Deutsch	Union County
E. Vernon Davis	Burlington County
Raymond J. Germain	Hunterdon County

Reference Committee on Constitution and By-Laws

Bakewell Room, 1st Floor

To consider:
- Amendments to the Constitution
- Amendments to the By-Laws

Lorrimer Armstrong, Chm.	Union County
Erwin P. Sacks-Wilner	Mercer County
Joseph R. Jehl	Passaic County
John Thompson, Jr.	Essex County
Nicholas E. Marchione	Cumberland County

Reference Committee on Miscellaneous Business

Rowsley Room, 1st floor

Reports of the:
- Annual Meeting Committee

Subcommittees on:
- Scientific Exhibit
- Scientific Program

Advisory Committee to Woman's Auxiliary

George G. Green, Chm.	Monmouth County
Raymond A. Taylor	Ocean County
R. Winfield Betts	Burlington County
Henry O. von Deilen	Morris County
Alan A. J. Stolow	Somerset County

Reference Committee on Resolutions and Memorials

Room 1332, 13th floor

To consider
Nominations for Honorary Membership
Nominations for Emeritus Membership
Resolutions
Memorials

Nicholas A. Bertha, Chm.	Morris County
Herschel Pettit	Cape May County
Paul K. Bornstein	Monmouth County
Raymond Gadek	Middlesex County
Charles P. Campbell	Bergen County

Reference Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Ralph M. L. Buchanan, Chairman, Warren County
Marcus H Greifinger, Ex-Officio, Secretary
Rudolph C. Schretzmann, Ex-Officio, Treasurer

31st Annual Meeting

Woman's Auxiliary

CHALFONTE, ATLANTIC CITY

MAY 18, 19, 20, and 21, 1958

Daily Schedule

Sunday, May 18, 1958

10:00 a.m.—Registration Opens—Breakfast, Luncheon, and Fashion Show Tickets
Lobby Gallery, Office floor, Haddon Hall
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

1:00 p.m.—Art Exhibit Opens
Lobby Gallery, Office floor, Haddon Hall

6:30 p.m.—Fellowettes' Dinner
Zodiac A, Lounge floor

Monday, May 19, 1958

9:00 a.m.—Golf Matches
Linwood Country Club, Linwood

10:00 a.m.—Registration — Breakfast, Luncheon, and Fashion Show Tickets
Lobby Gallery, Office floor, Haddon Hall
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

10:30 a.m.—Pre-Convention Board Meeting
Roberts Room, Lounge floor

3:30 p.m.—Tea and Fashion Show
Models: Atlantic County Auxiliary Members
Music Room, Lounge floor

8:00 p.m.—General Session of the 192nd Annual Meeting of The Medical Society of New Jersey—The members of the Woman's Auxiliary are invited to attend.
Viking Room, 13th floor, Haddon Hall

Tuesday, May 20, 1958

9:00 a.m.—Registration—Breakfast and Luncheon Tickets
Lobby Gallery, Office floor, Haddon Hall
Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall
General Session
Music Room, Lounge floor

12:30 p.m.—Luncheon
Carolina Room, Lounge floor

2:30 p.m.—General Session (reconvenes)
Music Room, Lounge floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge floor, Haddon Hall

Wednesday, May 21, 1958

9:00 a.m.—Inaugural Breakfast
Roberts Room, Lounge floor

10:00 a.m.—Post-Convention Board Meeting
Roberts Room, Lounge floor

12:00 noon—President's Luncheon for Incoming County Presidents
Roberts Room, Lounge floor

Golf Matches—Linwood Country Club
Chairman, Mrs. Matthew Molitch
Hospitality Lounge—Lobby Gallery, Office floor, Haddon Hall
County Scrapbook Exhibit—Lobby Gallery, Office floor, Haddon Hall
Art Exhibit—Lobby Gallery, Office floor, Haddon Hall
Chairman, Mrs. S. Eugene Dalton

SCIENTIFIC EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 19 and 20, 1958
9:00 a.m. - 3:00 p.m., Wednesday, May 21, 1958

Booth 1. Diseases of the Cervix and Their Office Management—Henry C. Falk, M.D., Beth Israel Hospital, New York, N. Y.

This exhibit displays by actual photographs of the cervices the various diseases of the cervix that one meets within the course of one's practice. It also shows how these conditions should be treated in the doctor's office.

Booth 2. Pneumoperitoneum as a Diagnostic Aid in the Diaphragmatic Area—Bernard Maisel, M.D., Nathaniel Finby, M.D., and John A. Evans, M.D., New York Hospital-Cornell Medical Center, New York, N. Y.

Anatomic deformities either above or just below the diaphragm are frequently difficult to evaluate. Diagnosis may be possible only by means of exploratory thoracotomy or exploratory laparotomy. The administration of air to the peritoneal cavity (pneumoperitoneum) frequently facilitates the study of the supra- and infradiaphragmatic areas, and particularly the silhouette of the diaphragm. This may establish the diagnosis and obviate exploratory and, at times, unnecessary surgery. The technic of administering pneumoperitoneum is described.

Booth 3. The Practical Diagnosis of Surgical Heart Disease—Julio C. Davila, M.D., Robert G. Trout, M.D., and Robert P. Glover, M.D., Presbyterian Hospital, Episcopal Hospital, and St. Christopher's Hospital for Children, Philadelphia, Pa.

The efficient application of surgical treatment for many of the congenital and acquired cardiac defects is now an accepted practice. Thousands of patients with a variety of intracardiac and vascular lesions have been subjected to surgery. The fundamental diagnostic criteria are well established and the practicing physician with his own facilities is in a position to make diagnoses of cardiovascular conditions amenable to surgery with considerable accuracy in 80 to 85 per cent of the cases seen. This exhibit summarizes in synoptic form symptoms, basic diagnostic criteria, longevity statistics, mortality rate and long-term follow-up studies. It contributes to answering the question: What is the optimum time for surgery? The exhibit as a whole is a practical and usable guide to the proper selection of patients for cardiac surgery.

Booth 4. Clinical Observations With Chlorothiazide as a Diuretic Agent in Congestive Heart Failure—Marvin C. Becker, M.D., Franklin Simon, M.D., Arthur Bernstein, M.D., Sanford Lewis, M.D., Frederick Weiss, M.D., Walter Nudelman, M.D., Milton Shoskes, M.D., Aaron Finkelstein, M.D., Frederick Wachtel, M.D., Arthur Perelman, M.D., William Carlin, M.D., and Normand Solomon, M.D., Cardiac Clinic, Newark Beth Israel Hospital, Newark

This display reports clinical experience with a new diuretic in 50 patients with severe congestive heart failure studied at the cardiac clinic. Chlorothiazide is a potent, orally effective, non-toxic non-mercurial agent. It is probably the most effective oral diuretic studied to date. Parenteral mercurials were discontinued in 60 per cent of the patients who were previously maintained on them. In most of the other patients organic mercurial injections were substantially reduced. Chlorothiazide may cause a diuretic response in some patients who are apparently refractory to mercurials. Brief comments will be made on studies now in progress as to the hypotensive and anti-anginal effects of the agent.

Booth 5. Complete Nutriment in Therapy of Peptic Ulcer—Asher Winkelstein, M.D., New York, N. Y.

Here is a new approach to the management of the patient with peptic ulcer. It is based on the dynamic theory of metabolism, which predicates that there exists a large labile pool of metabolic fragments stemming from the nutritional essentials ingested by the patient. Physiologic repair requires a ready and constant supply of materials from this labile pool. A complete nutriment replenishes the pool and supports these physiologic processes. Its mechanism of action is to: protect the ulcerated mucosa; systematically enhance ulcer healing and restore the patient to optimal nutrition and normal activity.

Presented here is the use of the complete nutriment in the treatment of 40 patients who had been refractory to conventional therapy including anticholinergic drugs, liberal ulcer diet and alkalis. The cases are shown through case histories, color transparencies, visual analogies and x-rays.

Booth 6. A New Short Acting Barbiturate—Irving M. Riffin, M.D., and Rudolf Preisig, M.D., St. Vincent's Hospital, Montclair

A new short acting barbiturate had been used in the operating room. This exhibit compares the chemistry and pharmacology of the new drug in relation to the others now in common use. EEG and EKG tracings obtained during injection of the new drug intravenously in the patient will be shown. The statistics revealing the adequacy of the drug for induction and for maintenance of anesthesia will be presented.

Booth 7.—Intra Cardiac Hemodynamic Studies by Left and Right Heart Catheterization—Harvey M. Ewing, M.D., Albert B. Sarewitz, M.D., Adrian M. Sabety, M.D., Gerald E. Muehsam, M.D., Seward J. Baker, M.D., William H. Taylor, M.D., and M. A. McLaughlin, M.D., Heart Unit, Orange Memorial Hospital, Orange

This is an exhibit of drawings, posters, and x-ray pictures showing the technics of right and left heart catheterization. It shows the nature of the data obtained in these studies, and the value of these data in the diagnosis of both congenital and acquired heart disease.

Booth 8. Integrated Orthodontic and Surgical Management of Cleft Lip-Palate Repair—Michael B. Collito, D.D.S., Lyndon A. Peer, M.D., John C. Walker, M.D., and Alvin Mancusi-Ungaro, M.D., St. Barnabas Medical Center, and Babies' Hospital-Coit Memorial, Newark

Shown here is a new approach in the surgical management of cleft lip-palate based upon recent investigations. Dental orthopedic adjustments are accomplished for the infant prior to surgical intervention. Records show the effect of orthodontic forces upon growth and development of the maxillary complex. This integrated procedure promises a sharp reduction in orthodontic problems coupled with a superior cosmetic and functional surgical result for the cleft lip-palate population.

Booth 9. Construction and Management of the Ileostomy Stoma—James T. Wolstenholme, M.D., Albert H. Levy, M.D., and Theodore Golden, M.D., Department of Surgery, Veterans Administration Hospital, East Orange

To prevent the high rate of complications reported with ileostomies, emphasis is placed on a planned approach in the construction and local management of the ileostomy stoma. This exhibit illustrates a method used at VA Hospital, East Orange, for the construction of the ileostomy, its immediate management by catheter drainage and the early application of an ileostomy bag. Practical points of ileostomy appliances will be stressed. The display suggests that ileostomy complications can be prevented by (1) construction of a carefully planned ileostomy, (2) early application of an ileostomy bag, and (3) full knowledge of the advantages and disadvantages of ileostomy appliances available to the patient.

Booth 10. Carbohydrate Metabolism in Pregnancy—Milton Gross, M.D., Joseph P. Donnelly, M.D., and Gerald J. E. Ansell, M.D., Margaret Hague Maternity Hospital, Jersey City

In this exhibit, studies in over 1,100 patients are summarized in charts, diagrams and tables. Various aspects of carbohydrate metabolism are presented including the origin and significance of glycosuria, ketonuria, obesity and reduced glucose tolerance. The incomplete adjustment of the carbohydrate system of the diabetic or pre-diabetic is implicated in the increased incidence of such factors as maternal obesity, large fetal size, abnormal parturition, and fetal wastage. Close attention to possible inadequacy of carbohydrate metabolism during pregnancy is stressed as a mandatory part of prenatal care.

Booth 11. The Role of Anesthesia in Maternal and Infant Mortality—Irving M. Riffin, M.D., Upper Montclair; New Jersey State Society of Anesthesiologists, and American Society of Anesthesiologists

The exhibit reveals that maternal and infant mortality can be reduced when an obstetrical service is covered 24 hours round the clock by trained anesthesiologists or "generalists" who are proficient in obstetrical anesthetic administration and infant resuscitation.

Booth 12. Thoracic Tumors of Childhood—Harold W. Dargeon, M.D., and Charlotte Tan, M.D., Children's Tumor Registry and Pediatric Service, Memorial Center, New York, N. Y.

Some tumors in the thoracic region of children are of congenital origin; other primary neoplasms develop as childhood advances. Some are metastatic. The following are illustrated in this exhibit:

Group I—*Primary Tumors*

Malignant: Bronchogenic carcinoma, mesothelioma, leiomyosarcoma, angioendothelioma, neuroblastoma and Ewing's sarcoma.

Benign: hygroma, enlarged thymus, teratoma, thyroid adenoma, lung cyst, hemangioma, neurofibromatosis, and neuroma.

Group II—*Metastatic Tumors*

Neuroblastoma, Wilm's tumor, Ewing's sarcoma, osteogenic sarcoma, and rhabdomyosarcoma.

Group III—*Lymphomas*

Lymphosarcoma, leukemia and Hodgkin's disease.

Booth 13.—Prevention and Treatment of Cardiac Arrest—Victor Parsonnet, M.D., Arthur Bernstein, M.D., and Burton B. Bergman, M.D., Newark Beth Israel Hospital, Newark

On the basis of a statistical study and critical analysis of cardiac arrest in 35 cases, the Newark Beth Israel Hospital now uses cardiac monitors on every anesthetized patient. This hospital also has organized a team for emergency treatment of cardiac arrest anywhere in the hospital, and training program for members of the team. Statistics on the incidence of arrhythmias on anesthetized patients are presented. The preferred monitor and alarm system will be demonstrated.

Booth 14. The "Mechanical Heart"—and Indications for Its Use—Alfred R. Henderson, M.D., Harvey Black, Robert Meijer, Ph.D., and Lucy Aiello, M.T., Asbury Park

The pump-oxygenator itself will be exhibited, flanked by posters illustrating the various cardiovascular anomalies for which the machine is used,

as well as a detailed illustration of its mechanism. Reprints of an article published in this JOURNAL are available to those interested in the details.

Booth 15.—Alcoholism Today—C. Nelson Davis, M.D., Henry M. Tracey, Clifford Lewis, and Eaton Roberts Malvern Institute, Malvern, Pa.

The exhibit stresses the importance of diagnosis in the treatment of alcoholism. This exhibit will display the group therapy technic employed in the treatment of alcoholism.

Booth 16. The Physician's Role in Home Accident Prevention—Samuel C. Southard, M.D., Walter B. Stewart, M.D., Atlantic City; and William F. Matthews, M.D., Montclair; New Jersey Chapter, American Academy of Pediatrics

This exhibit presents to the doctor in capsule form an accident control program that he can initiate in his community, including the mechanics of setting up a poison control center; a sample 5 minute talk to young mothers; a sample 20 minute speech to a service club; and suggestions for study.

Booth 17. Physical Survey in a Psychiatric Hospital—Thomas J. White, M.D., Martin W. Pollini, M.D., Nathan Frank, M.D., Marcus E. Carpenter, M.D., and Mustafa Naama, M.D., Hudson County Hospital for Mental Diseases, Secaucus

This exhibit consists of a statistical analysis of the physical findings found on patients in a general psychiatric hospital. Routine physical examinations were done on the entire patient population of the hospital. These findings are presented.

Booth 18. Cardiac Arrhythmias During Surgery and Their Control—Houck E. Bolton, M.D., Charles P. Bailey, M.D., Sheldon Bender, M.D., and William Weiss, M.D., Hahnemann Hospital, Philadelphia, Pa.; and West Jersey Hospital, Camden

Arrhythmias during cardiac surgery are serious and often result in a fatal outcome. These complications are more common in the patient with aortic valvular disease. We have used a satisfactory anti-fibrillatory drug which has reduced operative mortality in this type of heart surgery by 50 per cent. Its indications and application are demonstrated. The need of an anti-fibrillatory drug often occurs during general surgery as well as in the treatment of arrhythmias in the medical cardiologic patient. The influence of this anti-fibrillatory drug is best demonstrated by continuous electrocardiograms. Two series of patients are presented. A group in which the drug is used, is compared with a series of patients not receiving the drug.

Booth 19. Disaster Program for Small Suburban Hospital—William Pomerantz, M.D., St. Clare's Hospital, Denville

The purpose of the exhibit is to show: (1) Evacuation of patients from hospital, (2) Conversion of hospital for emergency plan, and (3) Traffic flow and control to hospital.

Booth 20. Common Pathologic Lesions—Plastic Wet Mounts in Natural Color—Martin R. Rush, M.D., George T. Hoffmann, M.D., and Alfredo D. Zavaleta, M.D., Monmouth Memorial Hospital, Long Branch

This exhibit displays specimens which depict common lesions of interest to all physicians. It also illustrates a relatively simple, inexpensive, and rapid method of preparing permanent specimens as a medical museum. The traditional method of educating medical staffs through medical museums has been gradually abandoned. Since medical education is a dynamic factor, this will be a plea for the reinstitution in general hospitals of this type of medical museums for teaching purposes.

Booth 21. Books—Significant in the Historical Development of Cardiology—Alfred R. Henderson, M.D., Asbury Park

Here is a chronologic exhibit of important books from William Harvey's *DeMotu Cordis* of 1628 to the most recent publication on open heart surgery. All important contributors to the developmental story of cardiovascular diseases are here, including original works of Harvey, Haller, Sydenham, Corvisart, Flint, Laennec, Hales, Aschoff, Whithering, Osler, and others.

Booth 22. Bergen Community Blood Bank—Bergen County Medical Society

This exhibit will tell the story of the Bergen Community Blood Bank Donor Groups where entire towns are covered free of charge.

Booth 23. The Cardiovascular Dynamics of Bowel Function—Alfred Halpern, Ph.D., Norman Shaftel, M.D., and David Selman, M.D., The Stuyvesant Polyclinic, Postgraduate Division, New York, N. Y.

Death after the straining associated with defecation is not rare. Several mechanisms involving the circulation of the heart, pulmonary and peripheral vessels have been suggested in explanation. This exhibit describes the circulatory dynamics observed during defecation of both normal and constipated patients. The data obtained, from several hundred patient measurements, describes the elevation of intrathoracic pressure occurring during straining and its consequent effects on the blood pressure, electrocardiogram circulation time, and the heart rate.

Booth 24. The Timed Integration of Stool Hydration and Peristaltic Stimulation in Constipation Correction—Alvin D. Yasuna, M.D., The Lebanon Hospital; and Alfred Halpern, Ph.D., The Stuyvesant Polyclinic Hospital, New York, N. Y.

The combination of the surfactant (DSS), with a peristaltic stimulant of proved clinical superiority, results in a refinement of the mechanics of constipation correction which most adequately meets the theoretical criteria for this purpose. This agent adds a new dimension to laxative therapy by integrating timed stool-softening with predictable evacuation.

Booth 25. Diuretics: Pharmacologic Action and Clinical Effects—Arthur DeGraff, M.D., Herbert S. Kupperman, M.D., Leonard B. Gutner, M.D., Walter Newman, M.D., and Lawrence Kryle, M.D., New York University College of Medicine, New York, N. Y.

Here are elaborated the general pharmacologic and therapeutic principles governing the clinical administration of diuretics. The mechanisms of action, therapeutic advantages and disadvantages, toxic manifestations and undesirable pharmacologic effects of the commonly used diuretics are described. The mercurial and non-mercurial diuretics are enumerated. Also covered is the action of diuretics in the clinical management of the patient with congestive heart failure. The possible use of these agents in other fields of medicine is discussed. Also reviewed are the effects of the adrenal corticoids upon the syndrome of congestive failure and their ancillary use in promoting diuresis.

EDUCATIONAL EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 19 and 20, 1958
9:00 a.m. - 3:00 p.m., Wednesday, May 21, 1958

Booth 1. Virus Diagnostic Methods—Practical Applications—Elmer L. Schaffer, Ph.D., Director of Laboratories, and J. Norman Welsh, M.S., in Charge of Virus Laboratory, New Jersey State Department of Health, Trenton

Exhibits will show basic procedures in diagnostic virology; the types of specimens to be collected for specific virus diagnostic services; their mode of transmittal to the laboratory; the data to accompany specimens; demonstrations of tissue culture technics; fertile egg technics; serologic reactions, and so forth.

Booth 2. Help for the Low Sodium Restricted Patient—New Jersey Heart Association, Inc., Newark

The exhibit has a twofold purpose: (1) it calls attention to a set of three new sodium restricted diet books, now available, for the three levels of sodium restriction; and (2) it points out that patients must be protected against hidden sources of sodium, such as water, medicines, home remedies, and the like.

A part of the exhibit is a set of 12 slides in an automatic rear vision projector featuring various sources of "hidden sodium."

Booth 3. Life Insurance Medicine Looks at Your Patient—Charles E. Kiessling, M.D., Royal S. Schaaf, M.D., and Annie Mary Lyle, F.S.A., Prudential Insurance Company of America, Newark

This exhibit shows how insurance companies evaluate your patients as life insurance risks. It demonstrates some of the data on which the evaluation is made and how it is made. It explains the difference between what you as a practicing physician think of your patient and what the insurance company thinks; why certain conditions looked upon as insignificant in clinical medicine might be evaluated differently by an insurance company. This will help you understand why patients whom you consider well and healthy might be charged an extra premium on life insurance.

Booth 4. Hearing Testing of School Children—Herbert E. Rickenberg, Director, Henry C. Barkhorn Memorial Hearing and Speech Center, Newark Eye and Ear Infirmary, Newark

The exhibit will demonstrate the technics of testing the hearing of school children; illustrate results of a recent survey of the South Orange-Maplewood Public School District, and, illustrate results of research presently being concluded of a new technic in surveying hearing losses in school children.

Booth 5. Chronic Illness Control—Committees on Chronically Ill and Conservation of Vision, The Medical Society of New Jersey; and Division of Chronic Illness Control, New Jersey State Department of Health, Trenton

Chronic illness control with emphasis on prevention of blindness by early detection of glaucoma through use of screening procedures routinely in physicians' offices. Photographs furnished by the Newark Eye and Ear Infirmary.

Booth 6. Career: Medical Technologist—New Jersey Society of Medical Technologists

The exhibit includes dioramas relating to the training of a medical technologist. To assist physicians, who may be called upon to give advice to prospective students in the field of medical technology, information and material concerning training and work done in this field will be distributed.

Booth 7. Exfoliative Cytology in the Diagnosis of Early Cancer—American Cancer Society, New Jersey Division, Inc., Newark

This display outlines the historical development of the smear technic, methods of procuring smears, and their preparation from the uterus, lung, stomach, urinary tract, colon and rectum. Also displayed are representative smears from each and the reported accuracy from several clinics. A panel is devoted to investigative aspects of the problem and which includes Dr. Papanicolau's work on breast smears, the Grahams' study of the SR reaction, the results of mass screening studies, the Shelby project, the Draghi tampon, and the self-obtained smears, and an outline of the current status of the cytoanalyzer.

TECHNICAL EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 19 and 20, 1958

9:00 a.m. - 3:00 p.m., Wednesday, May 21, 1958

Abbott Laboratories — Booth 28

Members of the medical profession will be cordially welcomed at Abbott Laboratories' exhibit of leading specialties and new products. Our representatives will be available at the exhibit to give information on the products and to answer any questions you may have.

American Ferment Co., Inc. — Booth 29

Falgos®, the buffered compound analgesic advertised only to the profession, will be featured. Acts quickly and without gastric upset. Also featured: Caroid and Bile Salts Tablets®, Alcaroid Antacid® and Supligol®, a whole bile-bile acid compound tablets.

Ames Company, Inc. — Booth 33

Featured at the Ames Company exhibit will be the latest developments in new, simplified diagnostic products, which are adaptable to routine examination and patient management. The many advantages of the new diagnostic products are quickly demonstrable, and you are cordially invited to stop at the Ames booth to see them.

Uristix®, a new "dip and read" single-strip test for both glycosuria and proteinuria, will be featured.

Ayerst Laboratories — Booth 22

A most cordial invitation is extended to all physicians to visit Ayerst Laboratories' booth where Theruhistin® and Premarin I.V.® will be featured. Our representatives will be pleased to supply you with up-to-date information and clinical reports on Theruhistin® and Premarin I.V.® as well as other Ayerst products.

Baby Development Clinic — Booth 8

Items of interest to doctors will be shown—for their own family use as well as for every type of patient. Lifebuoy Soap with germicide TMTD®; Tucks, the ready-to-use witch hazel pads; TFL flexible, disposable clinic droppers; full line of Evenflo® infant feeding equipment; premature nipples; nipple covers for hospital sterilization; Superplastic boilable bottles; Drinkup, a transition bottle top for children as well as for postoperative pediatric cases, excellent also for geriatric feeding.

Baby Service, Inc. — Booth 53

Baby Service extends a warm welcome to all attending the 192nd Annual Meeting of The Medical Society of New Jersey. The usual red roses will be given to the ladies who visit the Baby Service booth. The doctors will be interested in the latest methods employed to combat rash and produce a soft, fluffy diaper for use at home or in the twenty-seven hospitals served by Baby Service. Our attendants are most anxious to answer any question about the operation of New Jersey's largest diaper service. Please stop by and say hello.

The Baker Laboratories, Inc. — Booth 58

You are invited to visit our booth where Baker's Modified Milk and Varamel®, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss with you the special features of Baker Milk products which promote better tolerance, less colic, better gain and improved tissue turgor for bottle-fed infants.

E. and W. Blanksteen — Booth 3

Information and literature is available at this booth regarding The Medical Society of New Jersey plans of accident and health insurance.

The Borden Company — Booth A

Borden's Prescription Products booth is the place to discuss the latest information on infant feeding. On display is Borden's complete line of infant formula products. You will find the answer to milk allergy in either liquid or powdered Mull-Soy®, the pioneer hypoallergenic food. If you are encountering hyperirritability or excoriations, you'll be interested in Bremil®, a complete formula patterned after breast milk. For prematures Dryco® provides a flexible high protein, low fat diet, and don't forget Beta Lactose®, the ideal milk sugar.

Bristol-Myers Products Division — Booth 23

Bufferin®, the better-tolerated analgesic for long-term salicylate therapy, will be featured by Bristol-Myers. Also on view Ammens® Medicated Powder, an absorbent starch-base product of special value where moisture contributes to skin irritation; Minit-Rub®, a greaseless-stainless rubefacient and topical analgesic; and new Theraderm®, for long-lasting dandruff control.

Brunswick Surgical Supply Co., Inc. **Booth 43**

This year many physicians are more concerned than ever before with reducing office operating costs. As a service to the profession, the staff of Brunswick Surgical has developed a program designed to reduce office costs and provide the physician with greater office efficiency. A cordial invitation to discuss the savings and efficiency that this program may have for you is extended by the staff of Brunswick Surgical Supply Co., Inc.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth 66**

The extensive research facilities of "B.W. & Co.," both here and in other countries, are directed to the development of improved therapeutic agents and technics. Through such research "B. W. & Co." has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs. An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

Cameron Surgical Instruments Company **Booth 63**

Fiat Lux (Let There Be Light) and there was light—and it was created by miniature lamps attached to various instruments made by the Cameron Surgical Instruments Company. More light than has ever before been seen is now in a brand new safety (operating room) headlite being shown. The amazing thing is that the light is cold, using only 6 volts of electricity. Also about 100 other instruments shown now give almost "daylight" illumination.

The small (17 pounds) portable electro-surgical unit for eye, ear, nose and throat work is the world's finest, yet the least expensive.

Two new operating prism loupes are being shown for the first time.

Remember, your Cameron "Service Station" is in New York.

Center Laboratories, Inc. **Booth 34**

Center Laboratories offers the physician a complete allergy service. Stable, potent extracts standardized on a protein nitrogen, total nitrogen or weight/volume basis both for diagnosis and therapy are presented along with a complete line of office and laboratory accessories. Specialized equipment for the preparation of extracts will be demonstrated and technical problems in the preparation and standardization of extracts will be discussed by our technical representatives. Your comments and inquiries are solicited.

Ciba Pharmaceutical Products, Inc. **Booth 21**

The Ciba exhibit features Serpasil®—the original, pure crystalline alkaloid of rauwolfia. Serpasil® has been found extremely useful as a tranquilizer in treating patients whose adjustment to life is complicated by anxiety, irritability and various psychoses. Patients feel calm, yet in properly adjusted doses retain their drive and energy. It is highly effective in many conditions where barbiturates have been commonly prescribed.

The Coca-Cola Company **Booth 45**

Ice-cold Coca-Cola® served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City, New Jersey and The Coca-Cola Company.

Dalzo, Inc. **Booth 40**

Qualified representatives will be in attendance to demonstrate our complete line of products used in the treatment of peripheral vascular disease. Nulast® the light weight natural rubber elastic bandage that does not slip. Dalzoflex® Elastic Adhesive Bandages. Dalzoflex® Patch Test Dressings. Dalzoband® Medicated Bandages. Dalmaplast® Adhesive Strapping. The New Primer Bandage. Lestreflex®, Petronet®, Dalmas® and other items.

Desitin Chemical Company **Booth 30**

Desitin® Ointment: the pioneer cod liver oil ointment for the treatment of burns, ulcers, wounds, diaper rash.

Desitin® Powder: pioneer cod liver oil dusting powder for the treatment of intertrigo, diaper rash, exanthema, abrasions, etc.

Desitin® Hemorrhoidal Suppositories: relieve pain and itching, promote healing, give comfort in uncomplicated hemorrhoids, fissures. Contain no anesthetics or styptics.

Rectal Desitin® Ointment: for effective relief in simple hemorrhoids, pruritus and fissures. No anesthetics.

Desitin® Lotion: soothing, protective, mildly astringent for the treatment of pruritus, poison ivy and non-specific dermatitis.

Desitin® Cosmetic & Nursery Soap: supermild, non-allergenic, pleasantly scented, deodorant.

Desitin® Acne Cream: A non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris and skin blemishes, effective in removal of skin oiliness.

The Dietene Company **Booth 48**

Have you tasted Meritene® . . . the whole protein supplement that *does* taste good? Visit our booth, enjoy a Meritene® milk shake with its multiple nutritive values.

While you're there, review the Dietene Diet based on Dietene Reducing Supplement. It provides the rare combination of low calories (1000) with high intake of protein and all essential vitamins and minerals in an interesting, effective, *safe* weight reducing diet.

Doho Chemical Corporation **Booth 65**

Auralgan®, ear medication in otitis media and removal of cerumen.

Otosmosan®, effective, non-toxic fungicidal and bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears.

Rhinalgan®, nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

New Larylgan®, soothing throat spray and gargle for infectious and non-infectious sore throat involvements.

Rectalgan®, liquid topical anesthesia, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Dermoplast®, aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions. Also obstetrical and gynecologic use.

Eaton Laboratories — Booth 9

New chemotherapeutic nitrofuran for bacterial diarrheas and enteritis, Furoxone® (brand of furazolidone) tablets and liquid. Perorally effective against a wide range of enteric bacteria, both gram-negative and gram-positive, including many species of Salmonella, Shigella, Escherichia, Proteus, Streptococcus, Staphylococcus and organisms classed as coliforms and enterococci.

A new recourse for severe bacterial infections—even when other antimicrobials fail—Furadantin® Intravenous Solution often rapidly effective: in systemic infections such as septicemia (bacteremia), peritonitis, and other bacterial infections as of postoperative wounds and abscesses, when the organism is susceptible to Furadantin®; in severe genito-urinary tract infections when the patient is unable to take Furadantin® by mouth.

Encyclopaedia Britannica, Inc. — Booth 57

Encyclopaedia Britannica proudly presents its new 1958 edition, available to members and guests of The Medical Society of New Jersey. Direct from the publisher, during the 192nd Annual Meeting. The Special Exhibit offer, containing unusual terms and discounts, together with important services, is not available on the same basis in the physician's home or office, following the close of the convention.

Faulhaber & Heard, Inc. — Booth 4

Information can be obtained on professional liability protection upon inquiry at booth 4, maintained by your Official Broker, Faulhaber & Heard, Inc.

Protection is also available for professional assistants such as registered or graduate nurses, and x-ray or laboratory technicians.

C. B. Fleet Company, Inc. — Booth 59

Fleet will exhibit Clysmathane®, its most recent contribution in the field of medication by rectum—an advanced method of xanthine therapy. Clysmathane® is a stable solution of theophylline monoethanolamine; easily retained; rapid and uniform absorption; prompt and predictable blood levels; with no rectal irritation after prolonged use. Clysmathane®, in a disposable rectal unit, makes self administration easy any time and any place—and assures prompt therapeutic blood levels. Examine the unit and ask for samples and literature.

E. Fougera & Company, Inc. — Booth 64

E. Fougera & Company, Inc. cordially invites physicians to visit their booth where products in the fields of cardiology, dermatology and radiology will be displayed.

Professional service personnel will be present to discuss these products and supply clinical materials if desired.

Geigy Pharmaceuticals — Booth 16

The Geigy exhibit will feature Butazolidin® and Butazolidin-Alka®, potent non-hormonal anti-arthritic and anti-inflammatory agent also effective in the treatment of superficial thrombophlebitis; and Preludin®, non-amphetamine appetite suppressant virtually without CNS stimulation. Also on display will be Sterosan® Hydrocortisone Cream and Ointment, for comprehensive control of a wider range of dermatoses; Medomin®, the hypnotic which provides "natural" sleep; and Sintrom®, potent oral anticoagulant with intermediate duration of action.

Gerber Products Company — Booth 6

High Meat Dinners provide more than nine grams of protein per container. With Gerber High Protein Cereal and the Meats-for-Babies, they offer a wide choice of well accepted foods that adequately supply the complete proteins. Ask the Gerber representative for further information on these and other top quality baby foods.

Health Insurance Council — Booth 15

The Health Insurance Council was set up by the insurance business to provide information and technical assistance to physicians and hospitals in matters concerning health insurance.

Council representatives will be present and available to participate in the discussion on health insurance and related matters at the general session program planned for Monday evening, May 19.

An additional opportunity to obtain information on health insurance will be provided by the Council's exhibit, featuring simplified health insurance claim forms as well as Council publications.

E. I. Hillard Laboratories, Inc. — Booth 61

Colactin® effectively corrects the deranged physiology that characterizes functional disorders of the lower intestinal tract. Colactin® subdues overactivity, consolidates contents, promotes hydration of fatty fecal matter and re-establishes normal peristaltic activity in the lower bowel. It presents no hazard of impaction or obstipation. Rx—2 capsules t.i.d., before meals, initially.

Quadracine®. Clinical experience confirms that Quadracine® thoroughly suppresses the perpetuating factors of peptic ulcer and promotes healing without dietary restrictions and with a significant reduction in the rate of recurrence. Quadracine® enables the patient to maintain his normal daily routine. Rx—2 tablets q.i.d., usually 1 tablet after eating, another 1 hour later.

Hoffmann-La Roche, Inc. **Booth 49**

Lipo Gantrisin® is a long-acting form of Gantrisin®, the single, wide-spectrum sulfonamide. Because Lipo Gantrisin® provides higher, more prolonged blood levels for approximately 12 hours, most patients need only 2 doses a day.

Marsilid "Roche"® is a psychic energizer, the very opposite of a tranquilizer. Marsilid® has a pronounced therapeutic effect in depressed and regressed psychotic patients, in mild depression, as an appetite stimulant, and in promoting increased vitality. Marsilid® does not raise blood pressure. In mild depression, Marsilid® usually takes effect within a week or two.

Holland-Rantos Company, Inc. **Booth 60**

Simplicity with security keynotes the Koromex® exhibit; H-R representatives will gladly explain:

Why patients can easily and correctly place Koro-Flex Diaphragms®;

Significant features of Koromex (A) Vaginal Jelly® when "jelly-alone" is advised;

Three-fold effectiveness of Nylmerate® jelly and Solution Concentrate;

Clinical value, in minor skin disorders, of Hollandex® Silicone Ointment.

Knoll Pharmaceutical Company **Booth 31**

Vita-Metrazol® is indicated where apathy is the predominating symptom. It improves appetite, regulates sleep pattern and increases sociability. Vita-Metrazol® is Metrazol® Liquidum with prophylactic amounts of selective vitamin B complex components. Information concerning Vita-Metrazol® as well as Quadrinal®, Dilaudid® and the other Knoll preparations is available for your review.

Lamond Products, Inc. **Booth 42**

Lamond Products feature dermatologic products exclusively: Dermasorcin® and Dermasul®, medicated lotions in cosmetic bases for acne and seborrhea; Bur-Zin® (Burow's Emulsion) with Burow's solution, zinc oxide, talc, lanolin and olive oil, for eczematous eruptions, excoriated surfaces, infantile eczema, cradle cap and diaper rash; Dermastringe®, a tincture containing resorcin and salicylic acid for acne, seborrhea, fungus infections and skin cleansing; Bentical® Shake Lotion, flesh tinted lotion for pruritic states, prickly heat and insect bites; Sunprotectol®, hypoallergenic sunscreening lotion that promotes a tan while protecting against sunburn and windburn.

Lederle Laboratories Division **Booth 39**

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Achromycin V®, Aristocort®, vitamins and many other of our dependable quality products.

Liebel-Flarsheim Company **Booth 38**

Eli Lilly and Company **Booth 32**

You are cordially invited to visit the Lilly exhibit. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

Lloyd Brothers, Inc. **Booth 25**

Roncovite-MF®, Doxinate®, and Doxinate® with Danthron®, original products of Lloyd research, will be featured at this display.

Roncovite-MF® provides the new concept of complete anemia therapy due to the unique marrow activating effect of therapeutic cobalt, acting through erythropoietin (the erythropoietic hormone).

The Doxinate® family of products affords the physician a complete choice of medication for the management of all types of constipation.

Maltbie Laboratories Division
Wallace & Tiernan, Inc. **Booth 56**

You are cordially invited to visit the Maltbie Laboratories exhibit featuring: Desenex® Night & Day treatment of athlete's foot; Bifran® with a plus for obesity; Cholan® preparations with effective hydrocholeresis and superior spasmolysis; Caldesene® Medicated Powder for diaper rash, and Nesacaine®, the first local anesthetic more potent yet less toxic than procaine.

The S. H. Massengill Company **Booth 47**

Capable Massengill representatives would be pleased to discuss with you any Massengill products in which you are interested. Products being featured are Adrenosem® (the unique systemic hemostat); Homagenets® (the only solid homogenized vitamins); Obedrin® (superior weight reducing aid); The Salcort® Family (offering a complete range in arthritic therapy); Saferon® (the peptonized iron); Massengill Powder (the douche preparation of choice). If you wish them, literature and samples will be available.

Mead Johnson & Company **Booth 1**

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and complete product information. The exhibit will be staffed by specially trained representatives who will be prepared to provide you with information on any of these products or product "families:" (1) Tempra®—the first physician-controlled antipyretic analgesic in drop and teaspoon dosage form. (2) The Mead Johnson Formula Products Family —the most complete feeding service for well and sick infants. (3) The Deca Vitamin® Family—vitamins in three convenient dosage forms providing comprehensive vitamin protection for infants and children. (4) The Pablum® Products—featuring the new Pablum Assorted-Pak®. (5) The Colace Products Family for the management of constipation.

Medco Products Company **Booth 52**

Medco Products presents the Medco-Sonlator®, a new concept in therapy. As a diagnostic agent it helps to locate "trigger points" of pain in muscle and fascia. The simultaneous application of sound and stimulation through the sound head gives rapid relief in many musculo-skeletal and arthritic conditions. Ultra sound may be used separately, so too can the neuro-muscular stimulator. However, many physicians report superior results with the blended therapy of sound plus stimulation. Also on display will be the Medcolator®, the modern neuro-muscular stimulator.

New Jersey representative, David Levinson, Lakewood, New Jersey.

Medical-Surgical Plan of New Jersey **Booth 2**

Sixteen years of progress illustrating New Jersey Blue Shield's service to participating physicians and more than 1,700,000 subscribers will be graphically depicted in illuminated panels of the Blue Shield exhibit. One panel portrays the rapid enrollment growth of the plan while another shows payments through the years that physicians have received for services rendered to their patients.

At the booth, all visitors will receive an unusual souvenir of the convention. Personal photographs will be taken on the spot with a polaroid camera. Blue Shield representatives will present the 3 x 4 candids in an attractive pocket size photo-mount.

Blue Shield cordially invites physicians and their wives to visit its display and talk with Plan representatives, who will be glad to answer any questions pertaining to the operation and service benefits of the Plan.

The Mennen Company **Booth 5**

The Mennen Company will exhibit Baby Magic®, America's favorite baby lotion; famous Baby Oil and Baby Powder for anti-diaper rash protection; and, in addition, Mennen Quinsana®, the fast-acting food powder that kills athlete's foot germs painlessly.

Merck Sharp & Dohme **Booth 11**

A new and very promising diuretic is featured at the Merck Sharp & Dohme booth. Since the principal action of Diuril® is a marked enhancement of the excretion of sodium, chloride and water, it has been designated a saluretic agent. This new compound achieves a profound electrolyte and water diuresis without attendant toxic effects and other disadvantages peculiar to the mercurials and certain other diuretic agents.

Technically trained personnel will be present to discuss this and other subjects of clinical interest.

The Wm. S. Merrell Company **Booth 36**

Quiactin® for quieting . . . an improvement over present tranquilizers for tension-anxiety states; patients remain alert, feel better, and TACE®, a "treatment of choice" for suppression of lactation will be featured. You are invited to discuss these and other Merrell research products with our representatives.

Milex of New York **Booth 70**

The Milex Cancer Detection Program will be featured. It is specifically designed to detect uterine and cervical cancer in the asymptomatic stages. Routine office use of this procedure can virtually eliminate the mortality factor of uterine and cervical carcinoma which claims over 16,000 American victims annually.

Also on display are the incomparable Milex Folding Pessaries®; Tricho-San®, our effective therapy for trichomoniasis, moniliasis, and non-specific vaginal infections; Lestens®, our new treatment for pre-menstrual tension and dysmenorrhea; as well as other recent gynecologic developments.

The National Drug Company **Booth 68**

The National Drug Company exhibit highlights Parenzyme Aqueous® and Parenzyme B® (Buccal). The efficiency of the anti-inflammatory, anti-edema agents Parenzyme Aqueous® and Parenzyme B® is clearly substantiated for the treatment of traumatic wounds, ulceration, phlebitis, ocular inflammation and for loosening of bronchial plugs in severe pulmonary disease. Our representatives anticipate discussing with you the latest advance in enzyme therapy in the form of Parenzyme B® (Buccal).

Organon, Inc. **Booth 51**

Physicians are cordially invited to visit the Organon booth for information on new therapeutic specialties. Included among these will be: Adrestat®, the complete systemic hemostat; Liquamar®, the new and potent oral anticoagulant; Cortrophin-Zinc®, the long-acting aqueous ACTH: Wigraine®, the rapid-acting and complete migraine therapy; and Nugestoral®, the aid for the abortion-prone patient. Organon representatives will be pleased to discuss these advances in therapy with all interested physicians. Samples and literature will be available.

Ortho Pharmaceutical Corporation **Booth 27**

Ortho cordially invites you to booth 27 where our line of obstetrical and gynecologic pharmaceuticals will be on display. Featured will be Delfen® Vaginal Cream, Ortho's most spermicidal contraceptive, and Rarical® Iron-Calcium Tablets, an effective iron-calcium compound for use in iron deficiency anemias and in all cases requiring calcium supplementation. Rarical® Iron-Calcium With Vitamins Tablets, a complete prenatal supplement will also be displayed.

Ortho representatives will be happy to meet you and answer any questions you may have on Ortho products.

Parke, Davis & Company **Booth 46**

Medical service members of our staff will be in attendance at our exhibit to discuss important Parke-Davis specialties which will be on display.

Pfizer Laboratories **Booth 13**

Visit the Pfizer display which features Cosa-Tetracyn®, Cosa-Terramycin®, and Cosa-Signemycin®, Pfizer's glucosamine potentiated antibio-

tics. The Pfizer representative will be pleased to provide you with information on the company's broad line of antibiotics and specialty products.

The Purdue Frederick Company **Booth 41**

We cordially invite you to visit our booth where you will find our special representative on hand to answer your questions and offer you latest information and samples of our featured specialty pharmaceuticals:

Glutaxyme® Capsules and Powder—a nutritive supplement for the patient over 40.

Senokot® Tablets and Granules—time proved constipation correctives, with their allied products, Senokap®, Senobile® and Sonokot® with Psyllium.

Pre-Mens® (plain and with d-Amphetamine)—for multidimensional therapy of premenstrual tension.

Somatovite® Liquid and Tablets—for promoting weight gain and appetite in the undernourished, underweight, hyperexcitable child.

Sippyplex®—for comprehensive, peptic ulcer management.

A. H. Robins Company, Inc. **Booth 50**

Dimetane® and Robaxin® are the two new drugs featured at the A. H. Robins Company exhibit. Dimetane®, an antihistamine unexcelled by any other antihistamine in potency, therapeutic index and relative safety, is offered in 4 mg. tablet form, and exceptionally palatable Elixir, and in Extentabs which provide 10-12 hours of allergy control with one dose. Robaxin® tablets are gaining acceptance as the skeletal muscle relaxant of choice as clinical evidence accumulates of this significant new product of Robins research. Also shown are Allbee with C®, Ambar®, and Donnatal Plus®.

J. B. Roerig and Company **Booth 17**

Featured will be Atarax®, the new "Peace of Mind" drug. It's an all new chemical and is specially indicated for the "more normal" person, to bring relief from the common everyday tensions and anxieties. Co-featured with Atarax® will be Bonadoxin®, the anti-emetic for relief of the nausea and vomiting of pregnancy; also effective in postanesthetic nausea and postradiation sickness. Literature and samples are available to physicians at the booth which you and your friends are cordially invited to visit.

Ross Laboratories **Booth 24**

Current concepts in pediatrics stressing the critical aspects of preventive care and the development of the infant as a whole being. Your Similac® representative will be happy to discuss the role of physiologic feeding in providing optimum clinical benefits. Copies of the latest Ross Pediatric Research Conference Reports are displayed.

Sandoz Pharmaceuticals **Booth 67**

Sandoz Pharmaceuticals cordially invite you to visit our display.

Bellergal® Space Tabs assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate.

Sandostene® Space Tabs around the clock control of itching and hay fever.

BepHan® Space Tabs new approach to prolonged maintenance of low gastric acidity.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

Saratoga Springs Authority **Booth 7**

How the New York State-owned Saratoga Spa serves the physician and the patient is completely explained in this new exhibit. Changing cards tell the story of mineral baths and other types of treatments with naturally carbonated mineral water and the Saratoga Spa's year-round recreational activities. A booth attendant will take registrations and dispense information and literature.

(Member of the Association of American Spas)

W. B. Saunders Company **Booth 35**

New Saunders titles of special clinical significance include: Higgins & Orr, *Surgery*; Levine, *Clinical Heart Disease, Current Therapy* 1958; Beckman, *Applied Pharmacology*; Andresen, *Gastroenterology;* Florey, *Pathology;* and Cecil & Conn, *Specialties in General Practice.*

The *Medical, Surgical* and *Pediatric Clinics* are forever new and useful.

Schering Corporation **Booth 62**

The Schering exhibit will feature Trilafon®, extremely potent tranquilizer and antiemetic, capable of alleviating manifestations of emotional stress without apparent dulling of mental acuity.

Extraordinary potency in behavioral effects without corresponding increase in autonomic, hematologic or hepatic side effects provides a favorable therapeutic ratio and excellent versatility in clinical use.

G. D. Searle & Co. **Booth 14**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Enovid®, the new synthetic steroid for treatment of various menstrual disorders; Zanchol®, a new biliary abstergent; Nilevar®, the new anabolic agent, and Rolicton®, a new safe, non-mercurial oral diuretic.

Smith, Kline & French Laboratories **Booth 18**

SKF features (1) Vi-Sorbin®, the potent, modern tonic containing B_{12}, B_6, iron, and folic acid, and incorporating the newly discovered Absorption Enhancement Factor, D-Sorbitol; (2) Compazine®, the tranquilizer and antiemetic remarkable for its freedom from drowsiness and depressing effect; and (3) Combid Spansule® capsules, a logical combination of a potent, new inherently long-acting anticholinergic, and Compazine®, for b.i.d., 24-hour control of both physical and psychic factors in ulcer and other gastrointestinal disorders. Our representatives welcome the opportunity to discuss SKF products with you and to be of help in any way they can.

South Jersey Surgical Supply Company **Booth 54**

This year the South Jersey Surgical Supply Company will display the latest in office equipment, sterilizing equipment and technics, and physical therapy apparatus.

E. R. Squibb & Sons **Booth 12**

E. R. Squibb and Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed.

At booth 12, we are pleased to present up-to-date information on these advances for your consideration.

U. S. Vitamin Corporation **Booth 10**

On display . . . *new* 3-dimensional Bivam® supplies biologically active whole water-soluble citrus bioflavonoid complex (as provided in C.V.P.) with multiple vitamins and minerals. Extends prophylaxis beyond usual dietary supplements in pregnancy and lactation . . . in medical, surgical and gynecologic practice . . . in geriatrics.

The Upjohn Company **Booth 69**

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Walker-Gordon Laboratory Company **Booth 44**

You are invited to taste-test Walker-Gordon Certified milks. There is the new Certified Lo-Sodium® milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 mg. per quart. Walker-Gordon Acidophilus Milk, Certified Pasteurized Milk and Certified Skimmed Milk will also be available.

The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, New Jersey, is the world's largest farm producing Certified Milk. It includes over 2400 acres of farm land and 2690 cows and growing heifers.

It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk.

Walker-Gordon Certified Milk is distributed in the metropolitan area of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Wallace Laboratories **Booth 55**

Wallace Laboratories will feature:

Miltown®—A proved tranquilizer, Miltown® relieves both anxiety and muscle tension. Its toxicity is low, side effects minimal and it is well suited for prolonged therapy.

Deprol®—Consisting of Miltown® and benactyzine, has been effectively used for treatment of depression. It is safe, and side effects are minimal.

Warner-Chilcott Laboratories **Booth 20**

Pacatal®—Clinically proved as a profound ataractic agent, Pacatal® continues to demonstrate its value in the treatment of mental and emotional disturbances. Pacatal® is unique in its "normalizing" action, helping the patient to think normally and react in a more stable emotional pattern.

Peritrate®—Painful seizures often create fear in the patient with angina pectoris. Attacks can be controlled and fear arrested by prophylactic management with Peritrate®, the long-acting coronary vasodilator. Prescribed on a regular daily dosage schedule, Peritrate® increases coronary circulation and lessens the frequency and severity of attacks. In addition, nitroglycerin dependence is often dramatically reduced and exercise tolerance increased.

Winthrop Laboratories **Booth 26**

Featuring Plaquenil®, a new Aralen® derivative which is remarkably effective in inducing remissions in rheumatoid arthritis. Pharmacologically, Plaquenil® has approximately one-fifth the toxicity of chloroquine; clinically, the incidence of side effects is markedly reduced.

Dilcoron®, a new "flavor-timed," dual-action, coronary vasodilator for angina pectoris; orally for dependable prophylaxis and sublingually for immediate relief. The sublingual-oral tablet has a quick-acting layer of nitroglycerin 0.4 mg. over a central core of prolonged-acting pentaerythritol tetranitrate 15 mg.

Wyeth Laboratories **Booth 37**

Wyeth will feature:

E-P-S for the spectrum of stress—The E-P-S symbol serves to remind the physician that there is a Wyeth normotropic drug for each of the three great segments of the stress spectrum—Equanil®, meprobamate, Wyeth, an antianxiety factor with marked muscle-relaxant properties; Phenergan®, promethazine hydrochloride, Wyeth, for psychic sedation, and Sparine®, promazine hydrochloride, Wyeth, for acute or chronic psychotic disorders.

Polymagma®, the lower-dose antidiarrheal, containing Claysorb,* a new adsorbent having five to eight times the adsorptive capacity of kaolin. Polymagma® is Wyeth's brand of dihydrostreptomycin sulfate, polymixin B sulfate and pectin with Claysorb (activated attapulgite, Wyeth), in alumina gel.

*Trademark

Yorktown Products Corporation **Booth 19**

Exul® is a nutritive substance which aids the healing of peptic ulcer. Exul® offers both specific and general support to the physiologic requirements of healing. Peptic digestion of protein continues unhampered under Exul® therapy which makes unnecessary antacid, antispasmodic, or sedative drugs. The rapid healing of gastric and duodenal ulcers under Exul® therapy may be attributed to its unique protein-sparing action.

Annual Reports of County Societies

Bergen

Leo J. Fitzpatrick, M.D., President, Teaneck

This year the Bergen County Medical Society has continued to grow. As of the end of April, 50 new members have been elected to the Society so we now have an overall total of 681. The hard working Membership Committee under the chairmanship of Dr. Luke A. Mulligan has continued to perform an outstanding service for the Society. To him and his faithful colleagues on the committee, my special commendation. This increase means we now have 40 delegates to the Annual Meeting of The Medical Society of New Jersey.

The report of the President is actually the aggregate of the accomplishments of the various committees. I take this opportunity to thank all the chairmen and members of the committees who have worked so diligently this year.

Lack of space prohibits my commenting on all of the work of all of our active committees. There are some, however, which in my opinion have done yeoman work for the Society and to whose detailed reports I call your special attention.

The Public Relations Committee headed by Dr. George Heller has accomplished one of the most important projects from a public relations point of view in several years—the establishment of the Emergency Medical Service. This dramatic and vital service could not have become a reality without the enthusiastic, wholehearted cooperation of more than 20 per cent of our total membership. For this service alone, I extend the congratulations of the officers and members of the Society to the committee and to members who serve on the various emergency call panels.

The public medical forums in fall and spring have been continued and the committee has been exceedingly prompt and assiduous in handling unfortunate public relations episodes which had broken in the local press.

The Medical Practice Committee under Dr. Donald B. Hull has wrestled with several thorny problems in the field of ethics. The Graduate Education Committee under the chairmanship of Dr. Carl Wierum conducted a fine course attended by an unusually large number of members.

The Public Welfare Committee chaired by Dr. Richard P. Keating deserves commendation for the work of its subcommittees on Mental Hygiene, chairman Dr. Stanley E. Prentice and Public Health, Dr. Robert Nelson. Our representatives on the School Health Liaison Committee, Drs. J. T. Worcester, S. E. Prentice and A. M. DeSanto have spent a great deal of time and conscientious effort under the leadership of Dr. R. W. terKuile in perfecting the Standards for School Health Examinations.

Dr. Winton H. Johnson, Building Committee, has brought our permanent home closer during the past year; the Publications Committee, headed by Dr. Daniel B. Roth has continued to increase reader interest in our excellent monthly *Bulletin*; and the Speakers' Bureau, headed by Dr. Marshall F. Driggs, has conducted 67 talks on medical subjects before lay audiences. Finally, but far from least, the Judicial Committee has been asked to adjudicate 16 complaints. Its members, Drs. F. C. McCormack, chairman, LeRoy Black, A. W. Cloud, Thomas DeCecio and W. H. Johnson, have been very faithful in considering the positions of our members on the one hand and the high standards of ethical medical practice on the other.

The Woman's Auxiliary has had another active year and we are proud to acknowledge the value of their efforts. Before the end of our year, they will have completed The Medical School Scholarship Fund and have again established additional Nursing Scholarships. The past presidents will be honored by the presentation of Fellowette pins.

The Bergen County Medical Society was represented by its president at many meetings during the year. Some of the meetings were: The Passaic County Medical Society Dinner, the Bergen County Bar Association Dinner, the Bergen County Teachers Association Dinner, the Doctor-Clergy Dinner, the Bergen

County Heart Symposium and the forums arranged by the Public Relations Committee.

I especially wish to thank the members of the Executive Committee and the officers for their guidance and help during the year.

Judge Francis V. D. Lloyd, our legal counsel, has been very helpful and cooperative. Our accountant, Mr. T. J. Menzenhauer, has maintained an eagle eye on our finances and kept us within our budget.

The work at our new office at 50 Main Street has increased considerably this past year. It has been a great pleasure to work so closely with our fine office staff. I want to thank Mr. Allen W. Fincke, our Executive Secretary, Mrs. Marguerite M. Hughes, our Assistant Secretary and Mrs. Mary C. Sanford for their pleasant, helpful and efficient service.

I would have liked to have personally welcomed each member who attended the meetings this year, but since this was impossible, I wish now to heartily thank you for your interest and support in your Society.

Burlington

J. Arthur Steitz, M.D., President, Mount Holly

Our Society reached the goal of 100 members this year. The county population progressed at a rapid rate; the physician population increased accordingly and our Society's duties multiplied. The diverse duties falling to the secretary have led to the enlargement of the office facilities and staff. We are much indebted to our secretary, R. Winfield Betts, for his long, excellent labors.

Society business, for the second year, has been accomplished largely by the Executive Committee. The business meetings have been brief and concise because of this and by the use of the Society *Newsletter* for dissemination of information.

We thank the Woman's Auxiliary for their assistance throughout the year, and take pride in noting that one of their members, Mrs. John Voss of Riverton, is president of the State Auxiliary for the current year.

The scientific programs, under the chairmanship of Dr. John Rogers, have been excellent. We have enjoyed speakers of high calibre, including Dr. Catherine Bouco of Women's Medical College in Philadelphia, Dr. Garfield Duncan of Pennsylvania Hospital, Dr. Edwin O. Geckeler of Hahnemann Medical College, Dr. Joseph Stokes of Children's Hospital of Philadelphia, and Dr. Fred Harbert of Jefferson Medical College.

The meeting with the Burlington County Bar Association was again a highlight of the year with Professor Caleb Foote of the University of Pennsylvania Law School speaking on "Special Studies in the Behavioral Sciences." This was a provocative talk concerning a new field.

Our outstanding accomplishment was a joint project with the eight southern counties of the state. By our combined efforts the Medical Societies of these eight counties were able to keep the Camden Municipal Hospital for Contagious Disease as our Contagious disease center. The fact that this hospital is directly allied with the Virus Research Laboratory under the supervision of Louis Coriell gives us a facility second to none. Each County Society worked out a plan with its Board of Freeholders whereby there was an annual contribution to the hospital. This was a gratifying experience, indicating how long hours and patient endeavor on the part of all concerned resulted to our common advantage.

Cumberland

PAUL K. AYARS, M.D., President, Port Norris

The Cumberland County Medical Society was proud to have Dr. Albert B. Kump take office as President of The Medical Society of New Jersey for the year 1957-1958. A reception in his honor was held by our members at Haddon Hall during the 191st Annual Meeting of The Medical Society of New Jersey.

At this same meeting the following members were recipients of the Golden Merit Award for fifty years of service: Charles M. Gray, M.D., Vineland, George A. Davies, M.D., Elmer, Alfred G. Sheppard, M.D., Elmer, and John H. Winslow, M.D., Vineland.

A successful year was initiated at our annual outing at Palatine Lake in June, 1957 as guests of the Owens-Illinois Glass Company where we enjoyed a lavish outdoor feast of barbecued steaks and steamed lobsters and shrimp that left nothing to be desired.

The By-Laws were amended to change our annual meeting date from April to June. Officers will still be elected at the April meeting but will not be installed until the end of the June meeting.

A resolution was approved recommending to the Cumberland County Board of Chosen Freeholders that a mosquito extermination commission be established thus enabling us to obtain state funds for this purpose.

We regret with sorrow, the passing on June 24, 1957 of Dr. Louis J. Kauffmann—an active worker and outstanding member of our society.

New members elected include one general practitioner, two orthopedic surgeons, one anesthesiologist, and one honorary member.

Our pleasant relationship with the Cumberland County Pharmaceutical Association was further enhanced by our attendance at a joint dinner meeting on April 23, 1957.

I wish to thank Dr. David Baxter, Program Chairman, for arranging the following excellent meetings: October 8, 1957—Dr. A. Henry Clagett, Jr., Chief of the Cardiovascular Section, Memorial Hospital, Wilmington, Del.—"Cardiac Arrhythmias"; December 10, 1957—a film presented by the Upjohn Company—"Diagnosis and Therapeutic Advances in Liver Disease"; February 11, 1958—Dr. Richard T. Shackelford, Assistant Professor of Surgery, Johns Hopkins School of Medicine, Chief of Department of Surgery, Veterans Administration Hospital, Perry Point, Md. —"Peripheral Vascular Disease."

Dr. P. A. Ruggieri deserves special commendation for his splendid work in organizing a series of educational lectures at Newcomb Hospital in Vineland.

Our problem of collecting premiums for group hospitalization was solved through the efforts of Dr. Mary Bacon and Dr. Benjamin Berkowitz in obtaining our very efficient Mrs. Ida B. McCubbin for part time service.

Words cannot express my deep appreciation to our able secretary, Dr. Mary Bacon, for her superb handling of a difficult and painstaking job.

I want to especially thank the members of the executive committee for their cooperation and assistance, Dr. Samuel B. Pole, III, for his efficiency in handling our funds, Dr. Leonard Scott for the excellency of his reports to the press, and to our entire membership for entrusting me to serve them.

Essex

EDWARD G. GULLORD, M.D., President, Newark

Last October we had a highly successful dinner with our Woman's Auxiliary at which Dr. Albert B. Kump, President of the State Society, was the speaker. Dr. Kump honored our members who were in practice for 50 years or more by presenting them with Golden Merit award plaques.

On December 15, 1957, our Society moved its office to 120 Halsted Street, East Orange. We are presently renting in a new, air-conditioned building. Our suite was designed by a local architect, Mr. Raymond Thoenig. Dr. Frank S. Forte and his Building Committee are to be commended on their work in con-

nection with this move. This relocation to a more central area in Essex County has inspired greater committee activity, and chairmen have informed me that their committees like our new office setup. This is evidenced in the greater turnout of committee members. The parking facilities around the building are excellent, especially for our evening meetings when we have the entire building parking lot to ourselves. I am happy to have been instrumental in effecting this move, which I feel will awaken a greater interest in Society activities.

We held a special dinner in honor of the P. Ballantine & Sons Foundation for presenting our Blood Bank with a two hundred thousand dollar gift, with which to build a County Blood Bank building. Mr. Carl W. Badenhausen, President of Ballantine's, accepted our plaque. The doctors of Essex County are deeply grateful for the generosity of P. Ballantine & Sons. Others honored at this dinner were: Dr. William D. Crecca, founder and first president of our Blood Bank; Dr. Kenneth E. Gardner, president of our Blood Bank; and Dr. Eugene M. Katzin, its Medical Director. Mr. John S. Thompson, Chairman of the Blood Bank Building Committee, and his entire committee also received well-earned recognition for their splendid job.

Through our Public Exhibits Committee, of which Dr. Carye-Belle Henle is chairman, we are again participating in the "Greater Newark Science Fair." Members of our committee are on the Board of Judges. Our contribution will assist local science winners to attend and compete in the National Science Fair. Through this Committee, we also are participating in the "Newark Moves Forward" exhibition at the Newark Museum. We set up medical exhibits for the public from November through March and distributed medical public relations literature at the Newark Museum.

Our Society had a booth at the Trade and Industrial Show, developed by the Bloomfield Chamber of Commerce last November. Here we exhibited heart films to the public. We also distributed family health record books at this Fair and were encouraged by the public's response to our health education efforts.

Our Insurance Committee has been very active during my administration, reviewing many plans for life insurance for our members at group rates. Several companies have submitted good offers. Details have yet to be worked out. It is my hope that the next administration will continue this work so that an excellent life insurance plan may be made available to our members.

Our Program Committee, under the chairmanship of Dr. John L. Work, is commended on securing many fine speakers for us. In November, at our meeting at the VA Hospital in East Orange, we heard papers by: Dr. Gadiel Smith on "Obesity and Secondary Polycythemia." Dr. Julius Sobin, "Psychiatric Problems in General Practice." Dr. Lawrence Vaughn and Dr. William E. Philip, on "Surgical Treatment of Pulmonary Tuberculosis." Later that day we met at Hotel Surburban. Dr. William F. Dock of Brooklyn, spoke on "Control of Coronary Atherosclerosis." This was a wonderful and enlightening meeting with good audience participation in a question and answer period. At the March meeting, devoted to the "Treatment of Burns," Dr. Charles L. Fox of New York Medical College, presented an interesting paper on burn therapy. In April, we held a panel on the subject of "Your Stake in the Success of Voluntary Health Insurance." We were fortunate in being able to get Mr. Ardell T. Everett, President of the Health Insurance Council of the State of New Jersey and Mr. Benjamin B. Kendrick, Coordinator for New Jersey Health Insurance Council, as well as informed physician panelists to speak at this meeting.

Dr. Louis Grunt, chairman of our Diabetes Committee, conducted a highly successful Diabetes Detection Drive. The Blue Cross-Blue Shield lent us the lobby of their building, and we administered over 1,000 finger-prick blood tests during Diabetes Detection Week. On this occasion, 79 positive blood sugars were discovered.

Dr. John Thompson, chairman of our Constitution and By-Laws Committee, has been working on a complete revision of both documents. Although there was no time for this revision to be adopted during my administration, I hope the work on this revision will be continued.

Our Woman's Auxiliary has cooperated with us splendidly, and presented some very interesting programs of their own. "The Cardiac" was the topic of their Public Relations Day Program.

Dr. S. William Kalb, chairman of our Speakers' Bureau, reported that in previous years he has sent out about 250 speakers per year to speak before the public. By this May, he expects to have sent out over 400 speakers. This is an all-time record for a County Medical Society, and I commend Dr. Kalb on the excellent job that he is doing for our Society and the public relations of the medical profession in Essex County.

From the polls our Society has already taken, and the opinions voiced by physicians at our local hospitals, the majority of our members are for social security for physicians. During my term of office, we have been awaiting the outcome of the proposed Jenkins-Keogh legislation before continuing to advocate social security. I hope something will shortly be done so that the many physicians who want social security coverage will have it made available to them.

Our relations with the other professions have never been better. We have participated in programs with local attorneys through a newly established Medical-Legal Association; one of our members is president of that society. We have supported, in principle, legislation recommended by the Essex County Pharmaceutical Association; and we have appeared on panels and in health exhibits with the Essex County Dental Society on their fluoridation programs.

Last year, as I was beginning my term of office, I was very pleased that Dr. David B. Allman of Atlantic City, became the first President of the AMA that the state of New Jersey has ever had. I am now pleased that The Medical Society of New Jersey is about to honor one of our members, Dr. Kenneth E. Gardner of Bloomfield, President-Elect of The Medical Society of New Jersey. He will be inaugurated as President this May. Best wishes to you, Ken, as I know you will do a splendid job.

Mercer

A. James Fessler, Sr., M.D., President, Trenton

Recognizing that a great deal of public apathy has existed, and that the Mercer County Society, through its membership, shares in the responsibility of bringing the Salk vaccine to the people through an intensive publicity campaign, a period designated as an "All Out Poliomyelitis Elimination Campaign" was conducted during the Spring of 1957. The importance of vaccination was announced, but the Society feels this is an individual responsibility, and that the individual should avail himself of the opportunity to obtain the inoculations.

Every physician's office in Mercer County should be an immunization center, and every effort must be expended toward urging each citizen to visit his own physician to receive the inoculations, if the vaccine is available. It was recommended that a minimum fee be charged when the immunizations are given during the campaign period.

It was also maintained by the Society that vaccine purchased with public tax funds be used only for those who are unable to pay, and that the proper channel for utilization of publicly purchased vaccine be the clinics of the hospitals and established agencies.

DIABETES DETECTION WEEK

Diabetes Detection Week was observed in Mercer County, under the Chairmanship of Dr. Arthur Krosnick, during the week of November 17, 1957. The effort of the county program was coordinated with the Diabetes Control Program of the New Jersey State Department of Health, and included both educational and case-finding elements. The following activities were accomplished:

1. Newspaper releases were arranged to publicize the desirability and availability of tests.
2. A series of short radio announcements, recorded by well-known personalities of radio, television, stage, and screen, were given at Mercer County radio stations during Diabetes Detection Week.
3. A special program was tape-recorded and presented over station WBUD on November 17. The program consisted of an informal discussion of diabetes by Dr. Arthur Krosnick and two diabetic patients.
4. A short announcement of the Mercer County Diabetes Program was recorded and presented over station WTTM.
5. A public meeting was held on November 19. A film on diabetes was shown, and two members of the committee discussed diabetes control and answered questions raised by the audience. In addition, an exhibit of food models and dietetic materials was arranged by members of the Mercer County Dietetic Association and the New Jersey State Department of Health.

6. An announcement of Diabetes Detection Week was published in Mercer Society's *Bulletin* and a discussion was presented at one of our meetings.
7. Literature was provided to members of the Society for personal use and for distribution to patients.

The case-finding activities included both blood and urine tests (St. Louis Dreypaks or fresh fluid specimens). Each of the major hospitals in the county agreed to accept and test urine samples during diabetes week.

Dreypaks were distributed to industrial employees and to the general public via local boards of health.

Blood screening tests were made available to New Jersey state employees and were completed on the Hewson Clinitron at the State Department of Health Laboratory.

In summary, 842 blood tests and 2005 urine tests were performed. There were 19 persons who had positive tests, and were referred to their personal physicians for follow-up studies.

Our committee recommended that the Diabetes Detection and Education Program remain active at all times, and expressed the hope that our members will make routine tests for diabetes on patients seen and will follow-up all diabetes suspects by appropriate tests, either postprandial blood sugar and urine tests or glucose tolerance tests.

RADIO PROGRAM PARTICIPATION

On December 1, the President of our Society, Dr. A. James Fessler, Sr., and Dr. Raymond E. Miller, Chairman, Public Relations Committee, participated in the *Labor Talks It Over* program presented by radio station WTTM. According to Mr. Fred Walker, General Manager of the station, "the program accomplished a great deal to cement favorable relations between the Mercer County Component Medical Society and the AFL and CIO."

THE GREATER TRENTON SCIENCE FORUM

Our Mercer Society is one of the agencies serving as co-sponsor of The Greater Trenton Science Forum. This scientific lecture program is designed to keep the community informed as to the meaning and purpose of science, its impact on civilization, and its ultimate goals.

CANCER DETECTION PROGRAM

Drs. John F. Johnson, J. F. Wikoff, Ernest F. Purcell, Sr., J. N. Zimskind, and Samuel J. Lloyd participated in the showing of a film which outlines methods for the detection of early breast cancer. The participating physicians answered questions which were raised following the showings. The program was sponsored by the Mercer County Component Medical Society, Woman's Auxiliary to the Mercer County Component Medical Society; the New Jersey State Department of Health, Mercer County Chapter of the American Cancer Society, and Lit Brothers' Department Store.

TUBERCULOSIS CONTROL COMMITTEE

Our Tuberculosis Control Committee, under the chairmanship of Dr. George N. J. Sommer, Jr., has cooperated with tuberculin testing programs being carried out by the New Jersey State Department of Health and the New Jersey State Department of Education in county schools. The program, apparently, is quite successful, and promises to be very enlightening.

PUBLIC HEALTH SURVEY

At the invitation of the Mayor of Trenton, the Mercer County Component Medical Society is participating in a survey of the Bureau of Health, to ascertain how this department compares with those in cities of like size in the State of New Jersey. Mercer Society's representatives on the committee are Drs. Floyd D. Gindhart, Raymond A. McCormack, and Karl T. Franzoni.

EMERGENCY MEDICAL SERVICE

The establishment of a comprehensive emergency medical service has been one of the major projects of our Public Relations Committee, and final plans are now being formulated.

CONTRACT PRACTICE COMMITTEE

By unanimous action, the Society approved the establishment of the Contract Practice Committee as one of our regular standing committees.

GOLDEN MERIT AWARDS

Golden Merit Awards, established in 1957 by The Medical Society of New Jersey, at the instance of the Subcommittee on Public Relations of the State Society, as an expression of its pride in, and affectionate regard for,

those of its members who have completed fifty years as doctors of medicine, were awarded to Dr. Harmon H. Ashley, of Princeton; Dr. Felix Frisch, of Trenton; and Dr. Wilbur Watts, of Trenton, at our Annual Banquet, which was held December 11, 1957.

NURSE SCHOLARSHIP FUND

The Woman's Auxiliary to the Mercer County Component Medical Society held its Annual Charity Ball and Buffet Dinner for the benefit of the Nurse Scholarship Fund on Saturday, February 15, 1958. The affair was well attended, despite most unfavorable weather conditions. Proceeds were turned over to the Nurse Scholarship Fund.

SCIENTIFIC SESSIONS

Under the chairmanship of Dr. Otto C. Tomec, and with the assistance of Drs. Floyd D. Gindhart and John H. Gindhart, the following scientific sessions were presented:

"Gastric Tumors and Their Treatment"—Dr. Samuel F. Marshall, of the Lahey Clinic, Boston, Massachusetts.

"Endocrinology—Uses and Abuses"—Dr. Herbert S. Kupperman, of New York University, Bellevue Medical Center.

"New Advances in the Treatment of Cardiac Arrhythmia"—Dr. Samuel Bellet, Director, Division of Cardiology, Philadelphia General Hospital.

ANNUAL ELECTIONS

On February 12, 1958, the following members were elected to offices for the year 1958-1959:

President—Dr. Samuel J. Lloyd
Vice-President—Dr. John A. Kinczel
Secretary-Reporter—Dr. Lawrence I. Bonin
Treasurer—Dr. W. Laurence Bonnet

Middlesex

Gerard R. Gessner, M.D., President, New Brunswick

In January, 1957, Mr. Ernest Abelson gave a talk on investments. In February, the subject was "hypotensive agents." The speaker was Dean Brown of Seton Hall College of Medicine and Dentistry. The March meeting was addressed by Arthur Blakemore, Professor of Surgery at Columbia. He spoke on aneurysms and occlusive aortic disease. In April we heard a talk on rheumatic fever by Leo Taran, M.D. In May we joined the dentists of Middlesex County for our annual outing and heard an address by Edward Patton, the Secretary of State of New Jersey. In June we installed our new officers. In October we had a business session. In November we enjoyed our joint dinner with the pharmacists. And we closed 1957 with a film on peripheral vascular diseases and a review of proposed revisions in our constitution.

Monmouth

Theodore Schlossbach, M.D., President, Ocean Grove

Monthly meetings of the Society were held except in July, August and December. The Program Committee gave us both scientific and non-scientific sessions. Our best attended meeting was a dinner session where a representative of the Internal Revenue Service spoke on "Income Tax as Related to the Physician."

The regular dinner meeting with the dentists and pharmacists was enjoyed by all. Dur-

ing the year two delightful dinner dances were held under the auspices of the Woman's Auxiliary to the Medical Society.

We have developed a new advisory committee on professional liability. The other committees carried on with their usual efficiency, maintaining effective liaison with lay agencies such as Monmouth County Organization for Social Service, Monmouth County Heart Association, Monmouth Chapter of the Cancer Society, Monmouth Workshop, Red Cross, Monmouth County Mental Health Association, *et cetera.*

The County Society was represented by its President on the new Monmouth County Mental Health Board appointed by the Freeholders of Monmouth County for the purpose of promoting county mental health centers and passing on state allotments for funds for any of the mental health projects within the county.

We are proud to have one of our members eligible for receipt of the Golden Merit Award —George C. Reynolds, M.D., of Freehold, a graduate of the University of Buffalo, 1908.

Memberships have reached an all-time high with a total of 308 members. Of these, 283 are active members.

The Executive Committee meetings have been well attended and the smoothness of the year has been because of the interest and ability of this committee.

Ocean

Willis B. Mitchell, M.D., President, Toms River

The Ocean County Medical Society stressed both public health and public relations during the past year.

We achieved the following:

1. An Emergency Call System for our larger areas which has been greatly appreciated both by the public and First Aid Squads, police, telephone operators, *et cetera.*
2. A plan for a Medical Examiner, instead of the coroner system, was submitted to the Board of Freeholders. This proposal has been accepted and an appointment of Medical Examiner is forthcoming.
3. We again requested that the Freeholders appoint a Sanitary Inspector for the county.
4. We circularized employers regarding the prevalence of active tuberculosis among migrant workers.
5. We are completing details for Poison Control Centers in our hospitals.

We had interesting and well attended regular meetings at which medical or medical-legal films were shown.

The year ended with a dinner in honor of the Woman's Auxiliary with Mrs. John C. Voss, President of the State Auxiliary, and Dr. Kenneth E. Gardner, President-Elect of the State Society, as our guests.

Passaic

Samuel C. Yachnin, M.D., President, Passaic

The presidential address at the annual installation dinner held in September, 1957, emphasized the importance of rekindling a wider interest among member doctors in the affairs of the society, and fostering a greater community of spirit. To help implement this, and to supplement the monthly *Bulletin* so ably managed and edited by the staff, three membership letters were sent to each doctor throughout the year, covering matters of major and timely interest.

We arranged for three meetings held away

from the Society building at hospitals in the three geographical population areas of the county. The program committee was eminently successful in obtaining speakers of outstanding quality to cover subjects of the widest interest. A collation was served at each meeting at the Society Building by members of the Woman's Auxiliary. These measures helped to increase the attendance at meetings.

PUBLICITY

Favorable public relations with the newspapers and the general public were greatly enhanced through the efforts of Mr. Randall Norris, the Public Relations Counsel, who organized two affairs.

The first was the annual press dinner, attended by the representatives of the local county newspapers and members of the Welfare Council and the Public Relations Committee. The discussion was valuable and informative to both sides. An unwritten code of agreement has evolved, concerning the control of medical announcements, news stories and releases, emphasizing the use of ethical and accurate reporting of medical facts.

The second was the annual public health forums sponsored jointly by the Society and one of the local newspapers, held at one of the local high schools. Members of the Society constituted a panel at two meetings. These received wide newspaper publicity, and the response by the public was overwhelmingly enthusiastic.

COMMITTEES

A special Asiatic Influenza committee was appointed. It prepared newspaper releases and mailed informative newsletters to the members, to present latest factual information and suggestions for an orderly process of influenza vaccination. This served to allay panic and confusion.

The chairman of the Medical Practice Committee was recommended to serve as the chairman of the Public County Polio Vaccination Committee. The Society continued its program, instituted the previous year, of sponsoring polio vaccinations in the doctors' offices at a nominal fee.

The Committee on Diabetes and Nutrition supervised the program for the Diabetes Detection Drive. Two thousand Dreypaks were obtained through the efforts of the Passaic County Tuberculosis and Health Association and distributed to the pharmacists with the cooperation of the Passaic County Pharmaceutical Association.

The Judicial Committee and the Disputed Bills Committee disposed of a substantial number of matters in a judicial manner to the satisfaction of all parties concerned.

FINANCE AND ADMINISTRATION

No increase in county dues was required, despite a considerable rise in the costs of administration. Strong reserves for contingencies have been established in the general fund, physicians' relief fund and the building fund.

The Emergency Call Service continued to function efficiently and satisfactorily.

The revision of the Constitution and By-Laws has been completed. An appropriation has been made to publish it and furnish a copy to each member of the Society.

The County Society Building is functioning as a county health center as far as the facilities permit. It serves as permanent headquarters of the Society, the Woman's Auxiliary, the Homemaker Service, the Passaic County Chapter of the American Cancer Society, the Medical-Dental Service Bureau of Bergen and Passaic Counties and the Rh Negative Donors Club. The building is also used as a regular meeting place by the Lost Chords of New Jersey (an organization of laryngectomized people) and the local chapter of the Licensed Practical Nurses of New Jersey.

The Executive Offices are being ably administered by Miss Cornelia Horn, the Executive Secretary and her associate, Mrs. Lorraine Mirandon. They supervise the many complex details of the office, including receipt, sorting and dispatching voluminous correspondence, the collection of dues, management of Blue Cross Hospitalization accounts, control of the emergency call service and many other matters too numerous to mention.

The membership is steadily increasing:

Members in Society	584
New members	27
Deceased since June	9

The Officers and Board of Censors, comprising the Welfare Council, have devoted considerable time and effort to facilitate the work of the Society. To them and all of the members who have participated, a vote of thanks is herewith expressed.

Union

Thomas P. Fitch, M.D., President, Plainfield

On July 1, 1958, our Emergency Medical Service of the Union County Medical Society will celebrate its Tenth Anniversary. We are justly proud of the record. From July, 1948, to January, 1956, all calls were taken care of by members who volunteered to serve on the panel. Since 1956, the associate members have been responsible for all emergency calls. The operators of the Exchange have handled many problems, and have done so promptly, patiently and tactfully. We are grateful to the efficient telephone staff.

The Society placed an advertisement in telephone directories, announcing the Emergency Service. Patients not only call in an emergency, but also request information on various health problems. Inquiries have been received from newcomers to Union County who were former residents from California to Maine. Many have called to tell us how pleased they are with the medical service they received. The number of calls increases each year, as both old and new residents become familiar with our office and the many services available to them.

The Indoctrination Program for new members is now in its third year, and is bringing about a better understanding as to their duties and also their benefits through membership in the County Society. The two meetings a year, held in homes of our Woman's Auxiliary, have proved very pleasant and valuable. At the present time we have 44 associate members.

The Annual Outing at the Canoe Brook Country Club was a most enjoyable day. Some of the guests were interns and residents from the hospitals in the county, many from foreign countries. They brought their cameras and took pictures of the beautiful countryside. The regular meetings of the Society were informative and instructive. A new system was started about two years ago, of presenting each member with a copy of the Executive Committee meeting minutes, as he enters the meeting room. This gives an opportunity for reading and consideration. It saves a great deal of time and discussion, and permits our meetings to close at a reasonable hour.

The Medical Assistants' Society has grown in number and enthusiasm since it was organized last year. Inquiries have been received from three counties interested in forming chapters, and we look forward with great interest to the growth of the Medical Assistants Society throughout the state.

The Society lost several outstanding members last year by death. We now have 512 active members, 44 associate members, 9 members taking residencies or semi-retired, and 13 emeritus members. Total membership is 578.

The Woman's Auxiliary has been as always very busy with projects, including the Nurses' Scholarships and the Homemakers Service. An outstanding speaker in February was United States Senator John W. Bricker, who addressed the joint meeting of the Union County Medical Society and the Woman's Auxiliary. The Woman's Auxiliary also assisted the County Society in plans for the first essay contest sponsored by the American Association of Physicians and Surgeons held in Union County. The contest is approved by The Medical Society of New Jersey and the Union County Medical Society. The three winners are outstanding students and are from St. Mary's High School, Elizabeth, who submitted excellent essays on freedom in medical practice.

The many details in the daily management of our offices were taken care of efficiently by our Executive Secretary, Miss Rogers, and Mrs. Brown, her assistant. It was with deep regret that we accepted the resignation of Mrs. Brown when she moved out of the County. In the three years she was in the Executive Offices she served the Society with devoted interest, and she will be greatly missed. We are most fortunate in having our highly competent Miss Rogers continue with us.

The committees on Public Relations, Program, Outing, Emergency Medical Service, Indoctrination, Blood Bank and Mental Hygiene were most active, and the others were always ready and willing to serve when called upon. My deep appreciation to the members of all the committees, and to the officers, for their support throughout the year. They have been most helpful, and all credit for a successful year is due them, for their diligence and loyalty.

Announcements • • •

Eye Pathology Course

An intensive course in normal ocular histology and histopathology will be given June 2 to 7, 1958, from 2 to 6 p.m. at the New York Eye and Ear Infirmary. The slides and specimens will be drawn from one of the largest collections in the world. Only 15 doctors will be admitted to this course. The fee is $100. For further information, write to Registrar, Institute of Ophthalmology, New York Eye and Ear Infirmary, 218 Second Avenue, New York 3, New York.

EKG Course

A new course on "The Physiologic Basis of Clinical Electrocardiography" is offered by the New York University Graduate Medical School during the week of June 2. It will be given in the air-conditioned classroom of Alumni Hall.

This is designed for physicians interested in the fundamentals of clinical electrocardiography interpretation. Clinical problems are presented. Informal interruptions, questions and discussions are encouraged. The material presented is largely original. Tuition: $75. For more details, write: The Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Golf Tournament

The American Medical Golfing Association will hold a tournament June 23, 1958, at the Olympic Lakeside Country Club, San Francisco, California. This will be a day of relaxation with golf, luncheon, banquet, and a prize for everyone. Tee off time 8 a.m. to 2 p.m. We invite all golfing doctors to attend. Handicaps scratch to 30 in flights.

For more information, airmail your query to Dr. James J. Leary, 450 Sutter Street, San Francisco.

Medical Lecture Tour to Asia

The Pacific Academy of Ophthalmology is sponsoring a tour to countries of the orient following the International Congress of Ophthalomolgy in Brussels in September, 1958. The purpose of this tour is to hold joint meetings with ophthalmologists in Pakistan, India, Thailand, the Philippines, and Hong Kong.

Our government has given its support to the plan of stimulating and facilitating a continuing exchange of information, treatments and devices for the care of the ill and the blind.

The reception of a group of physicians from the West throughout Asia will certainly be most cordial and will assure the success of this enterprise.

The ophthalmologic and medical material in all the countries is interesting and should be of value to members of the tour.

Physicians other than ophthalmologists and their families are also welcome to join this trip!

Those desiring to participate in the graduate lectures and seminars on medical subjects pertinent to ophthalmology should airmail a letter to:

William John Holmes M.D.
280, Alexander Young Building,
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If you're going to the AMA convention in June, you might as well extend the trip a bit westward and visit Hawaii. To combine business with pleasure, attend the Hawaiian Medical Conference in Honolulu July 1, 2, and 3. The scientific program includes breakfast panels and afternoon clinics. Some attractively planned travel packages are available. For further details, write to Medical Tours, p.o. box 3433, Chicago 54, Illinois.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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BRONCHIECTASIS AND ACUTE PNEUMONIA

William Ruberman, Irving Shauffer, and Thomas Biondo, The American Review of Tuberculosis and Pulmonary Diseases, November, 1957.

● Bronchiectasis should be suspected when the roentgenogram of a patient with recent acute pneumonia shows very slow resolution of the pneumonic process and persistence of parenchymal rales and productive cough are noted.

Introduction. Bronchiectasis has been considered a disease that originates in childhood after a severe respiratory infection. During the past ten years, however, studies on young adults who recently had bouts of acute pneumonia suggested that adult infections might also be a cause of bronchiectasis. Studies of such "postpneumonic bronchiectasis" have indicated that in some instances the bronchogram naturally reverts to normal. The present study is concerned with the incidence, diagnostic features, and stability of bronchiectasis first discovered after recent pneumonic infections.

Methods. The clinical records and roentgenograms of 94 patients on whom bronchograms were performed over a 28 month period at the U. S. Army Hospital, Fort Dix, New Jersey, were reviewed. The first group consisted of 69 patients selected for bronchography from a total of 1,711 patients seen with acute pneumonia. The second group consisted of 25 patients whose history or chest roentgenograms suggested chronic bronchiectasis. Patient selection of bronchography was done on the basis of uniform criteria.

Bronchography was performed on the patients with pneumonia not less than one month after all clinical evidence of activity had subsided, and only after any residual roentgenographic abnormality was shown to be stable for at least three weeks. Repeat studies were made in 24 instances and each was performed at least eight weeks after the preceding one. All of the patients were bronchoscoped immediately prior to the first bronchogram.

Bronchiectasis was diagnosed only by the presence of obvious cylindrical or saccular dilatation of the bronchial lumen. No untoward reaction to the procedure was encountered except in patients with bronchial asthma. The latter all developed moderately severe wheezing that responded satisfactorily to standard therapy.

Results. Of the 69 patients who recently had acute pneumonia, 29 were found to have bronchiectasis. One patient had an abnormal bronchogram that reverted to normal on the repeat study. Of the 18 patients who had not had an immediately preceding pneumonia, 5 had bronchiectasis and 13 were normal. Seven patients with asthma and chronic cough were studied. Six were found normal and one patient had an abnormal bronchogram.

The 29 patients with recent acute pneumonia who had bronchiectasis represent 1.7 per cent of the total number of patients with pneumonia seen during the same period. There was no significant difference in the past respiratory history of the bronchiectatic subjects compared with the group found to have normal bronchograms. There were significant differences, however, in the nature of the immediately preceding pneumonia in the two groups. In the bronchiectatic group the mean duration of roentgenographic evidence of pneumonia was two months, while it was one month in the normal group.

There was no significant difference between the two groups with respect to the extent of the pneumonic process as seen on the roentgenogram. A significantly greater proportion of patients in the group with bronchiectasis had prolonged fever and leukocytosis than of those in the nonbronchiectatic group, while there was no difference in the frequency of elevated cold and influenza hemagglutinin titers.

There was a significant difference between the two groups in the physical findings of the chest. While persistent parenchymal rales for one or more weeks following the subsidence of all acute manifestations of the pneumonia were noted in 75 per

cent of the patients with bronchiectasis, this was true in only 11 per cent of the patients in the nonbronchiectatic group. There appeared to be a similar increase in the frequency with which productive cough was present in the bronchiectatic group.

In 20 patients, of the 29 studied, there was a direct correlation between the site of the bronchiectasis and the location of the preceding pneumonia.

Eighteen patients had bronchograms performed for indications other than those arising during the course of an acute pneumonia. All but three of this group were seen initially because of acute nonpneumonic respiratory infections (pharyngitis, bronchitis), and a suggestive respiratory history or abnormal chest roentgenogram. Five patients in this group were found to have bronchiectasis and 13 had normal bronchograms.

No differences were found in the two groups with regard to past history of pulmonary disease.

Seven patients with bronchial asthma were bronchographed because of the presence of bothersome, chronic productive coughs. Six of these had normal bronchograms. The seventh had an irregular dilatation of an intermediate bronchus.

Discussion. The results of this study indicate that bronchiectasis is a common pulmonary lesion and that its presence should be considered during the course of an acute pneumonia when certain clinical features are manifest. The most important of these features is a persistently abnormal chest roentgenogram, indicating incomplete resolution of the pneumonic process.

Parenchymal rales that persist longer than clinical signs of activity are of considerable importance. If, in addition to the above findings, the patient's pneumonia is characterized by prolonged fever, continued productive cough, and leukocytosis, the diagnosis of bronchiectasis is rendered more likely.

A bronchogram is warranted in every case. The procedure is easy to perform, carries no significant danger, and is the only objective method of demonstrating the presence and extent of the abnormality.

In the present series only one of 14 patients with bronchiectasis, in whom the examination was repeated, showed reversion of the process to a normal state.

Undoubtedly, persistent but reversible bronchial dilatation does occur after a pneumonia although the occurrence is not common. Furthermore, the presence of artefacts and the difficulties inherent in borderline diagnosis should caution against overstating the problem.

In the group of 18 patients bronchographed because of an abnormal respiratory history, 5 patients were found to have bronchiectasis. Specific history of rapidly repeated bouts of pneumonia, all of which cleared rapidly, was not found to be indicative of bronchiectasis. The roentgenographic finding of localized emphysema, segmental atelectasis, or honeycombing was confined to the bronchiectatic group. A plain film of the chest, if it shows the positive findings noted above, is therefore of some value in the pre-bronchographic diagnosis of bronchiectasis. A normal chest roentgenogram in no way excludes the possibility of the presence of bronchiectasis.

The relationship of a preceding pneumonia to the bronchiectasis is uncertain. An underlying bronchiectasis could predispose to a more protracted course of pneumonia or, alternatively, a more severe pneumonic infection could so damage normal lung as to leave some permanent damage in the form of bronchiectasis.

It is believed that the available evidence does not warrant a definite conclusion on the subject. The mere association of two events does not denote a cause and effect relationship. The most that one can say is that the bronchiectasis first noted after a recent pneumonia may possibly, but not definitely, have been caused by an acute infection. Further proof will be necessary to establish this as a certainty.

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

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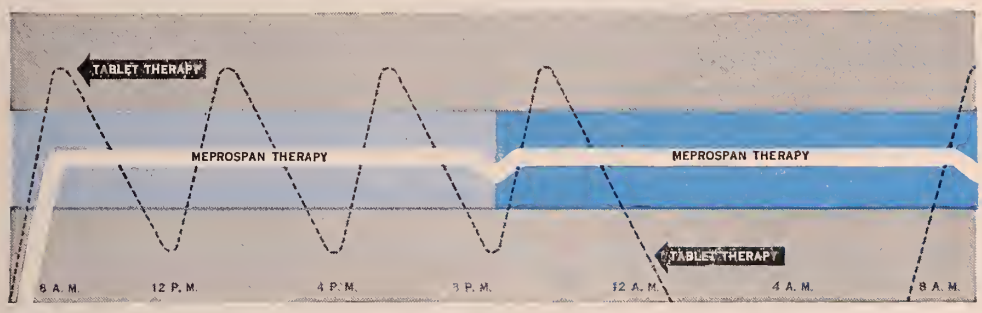
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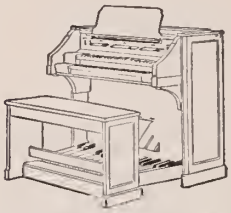
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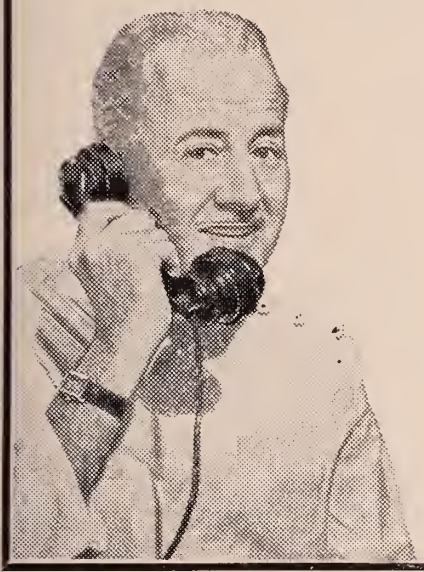
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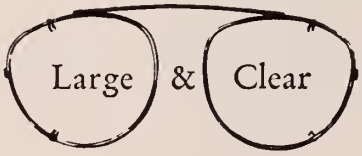
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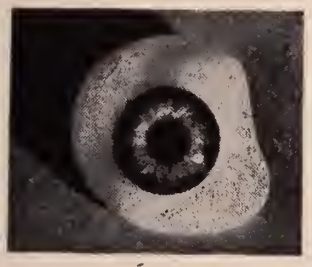
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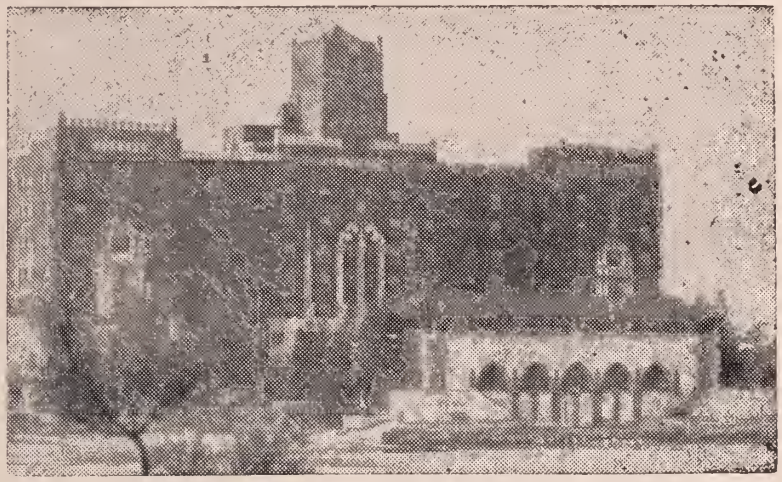
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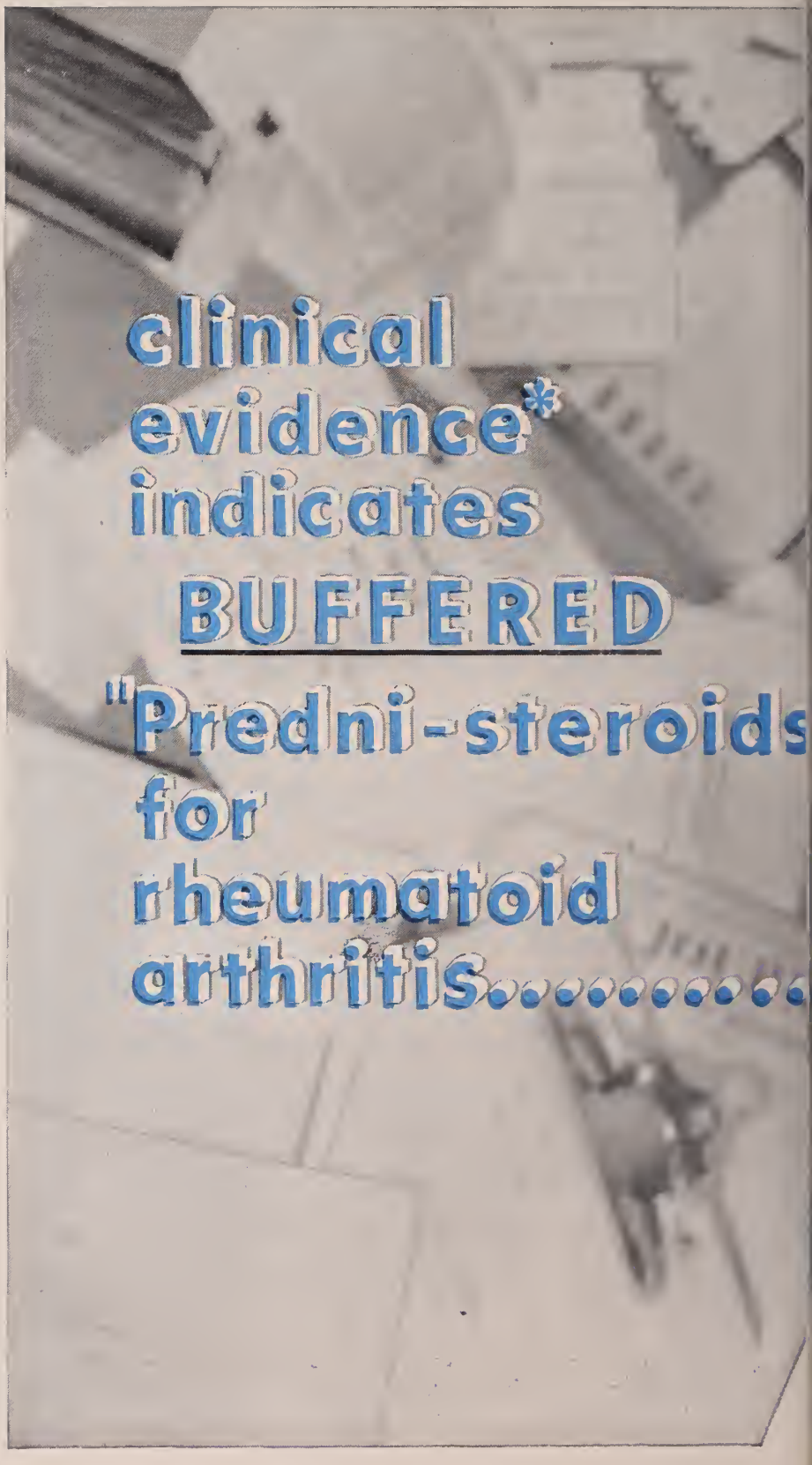


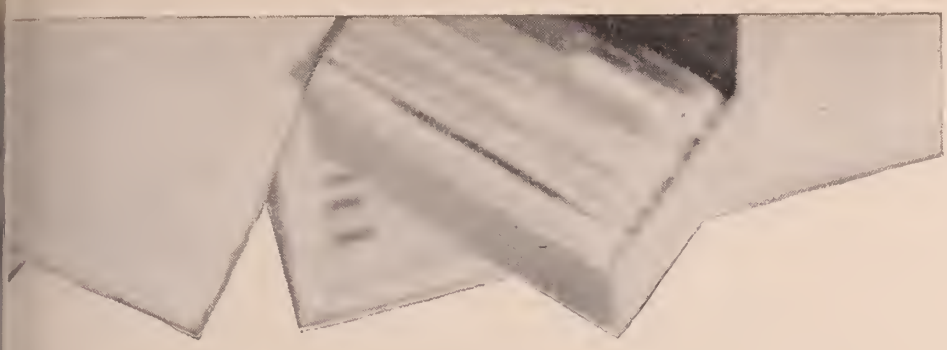
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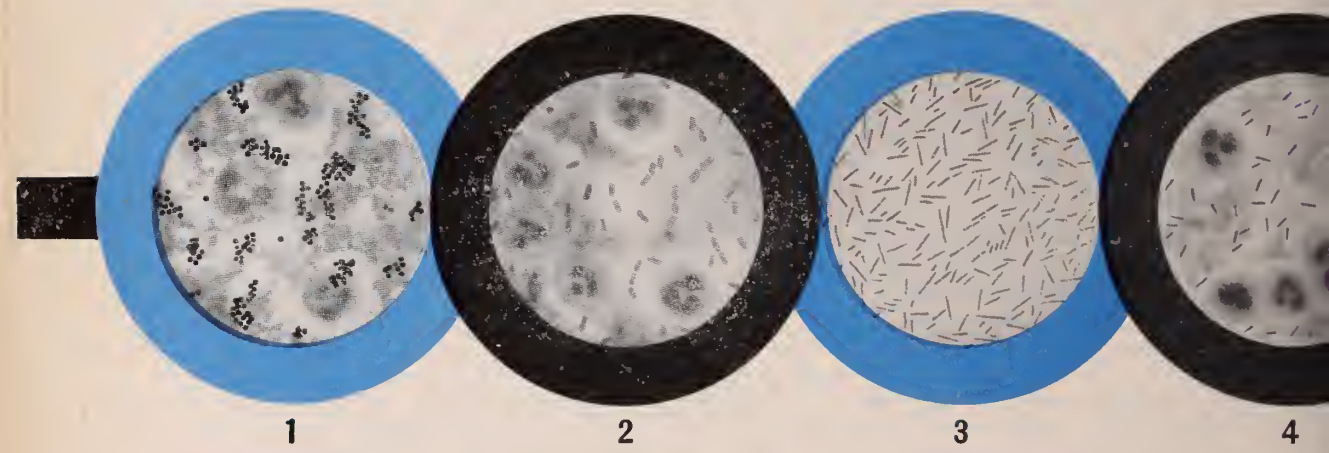
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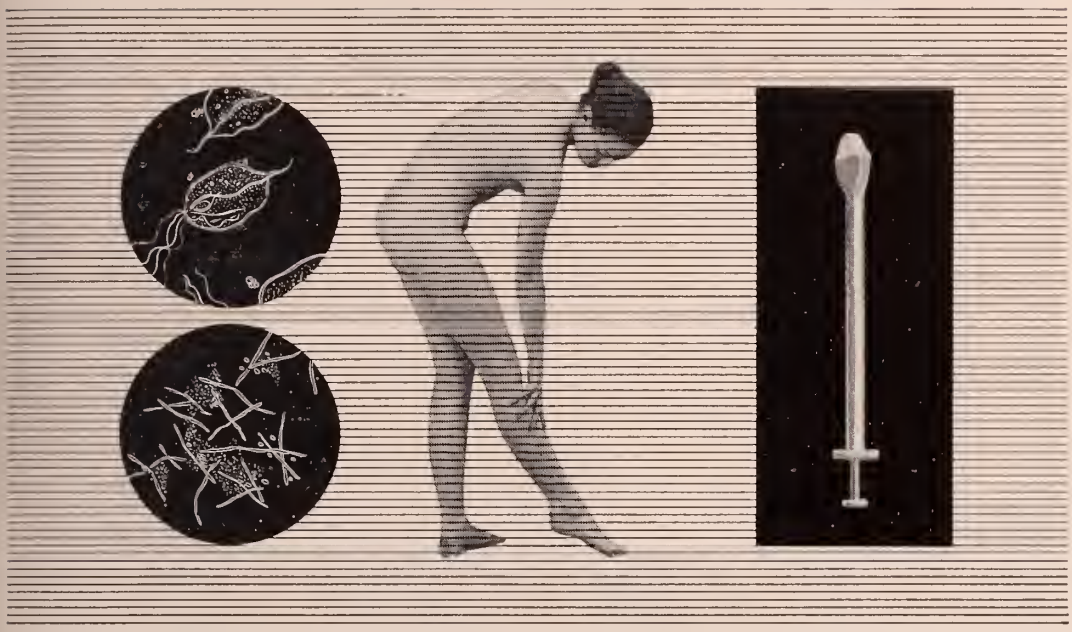
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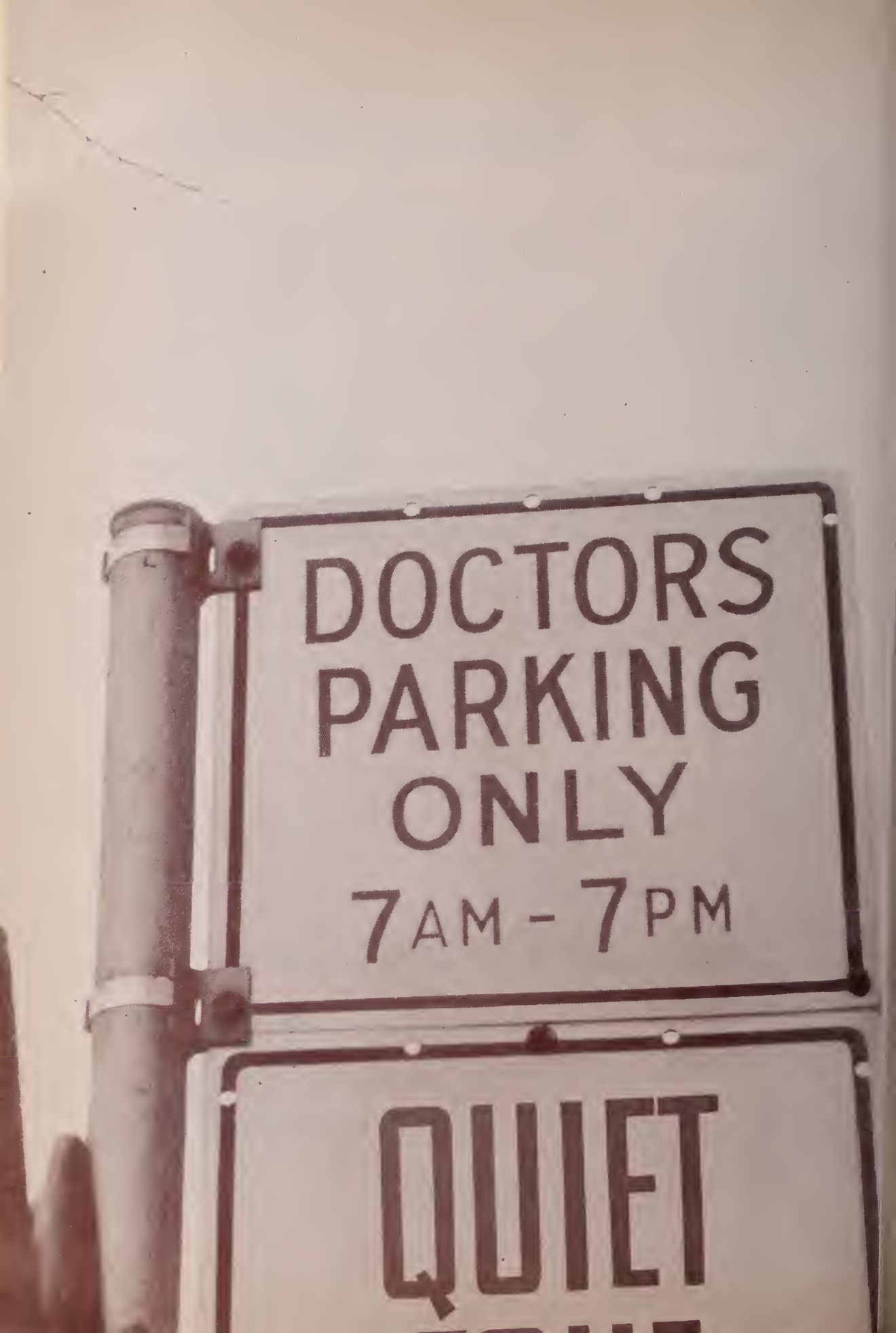
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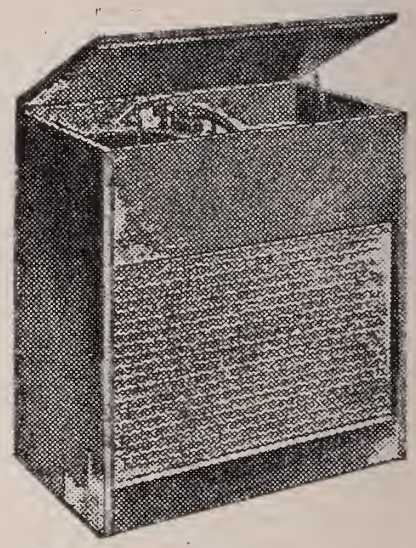
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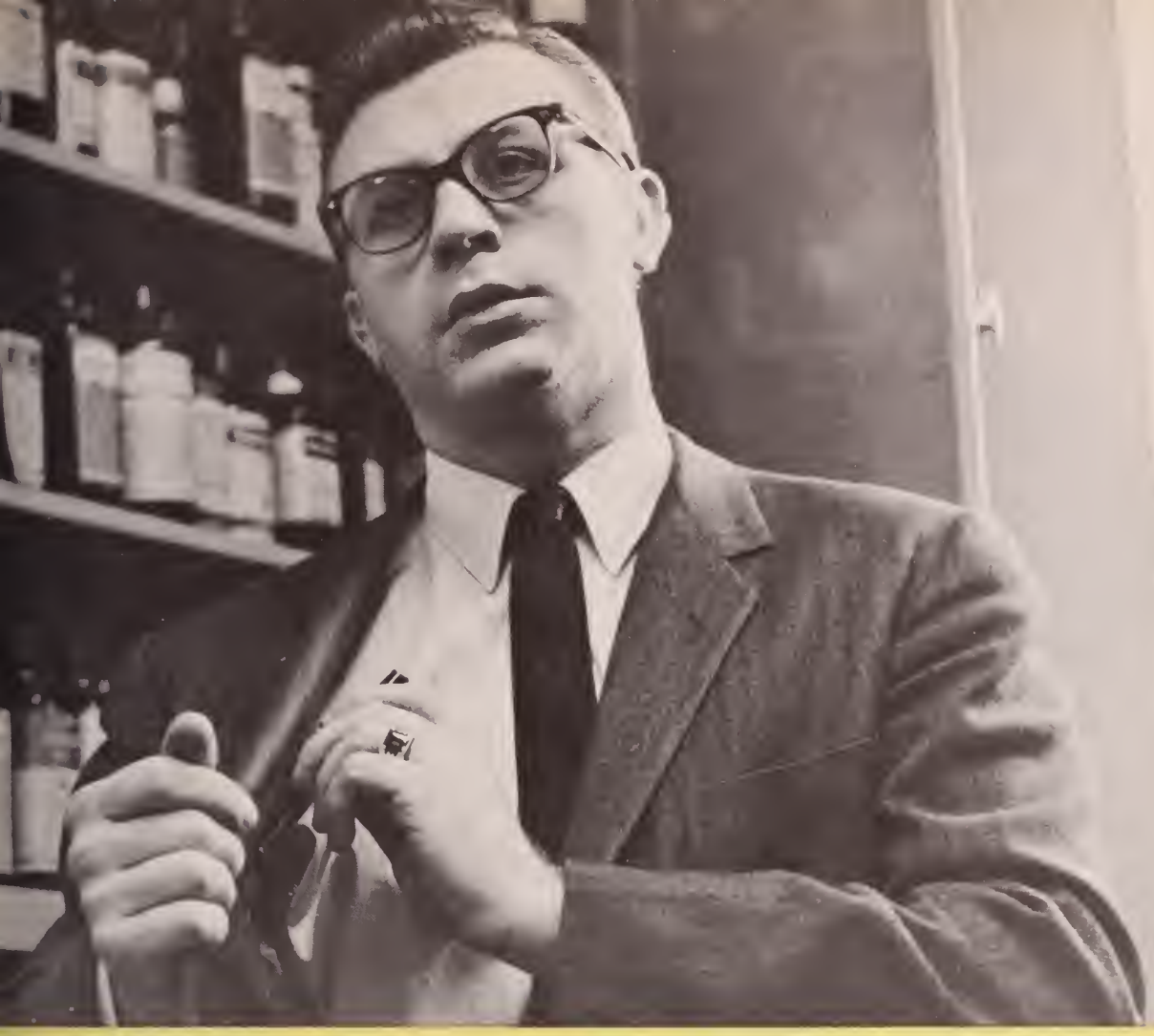


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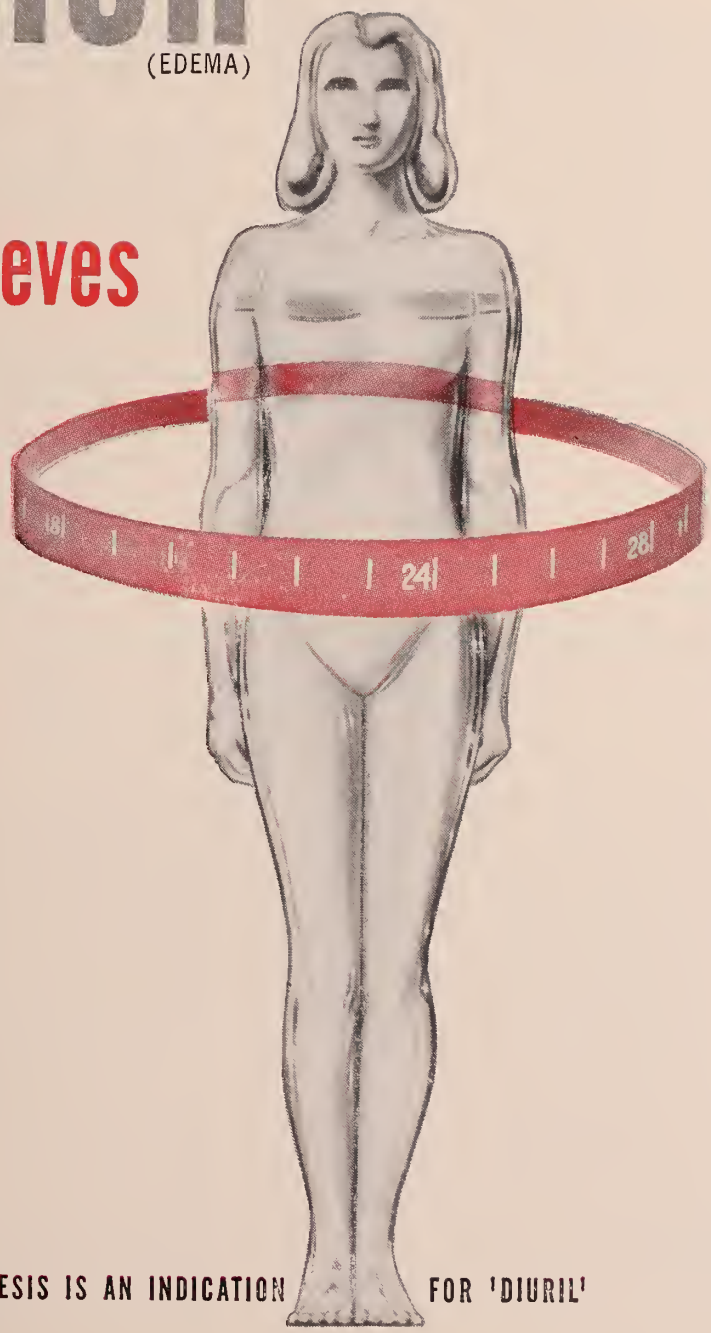
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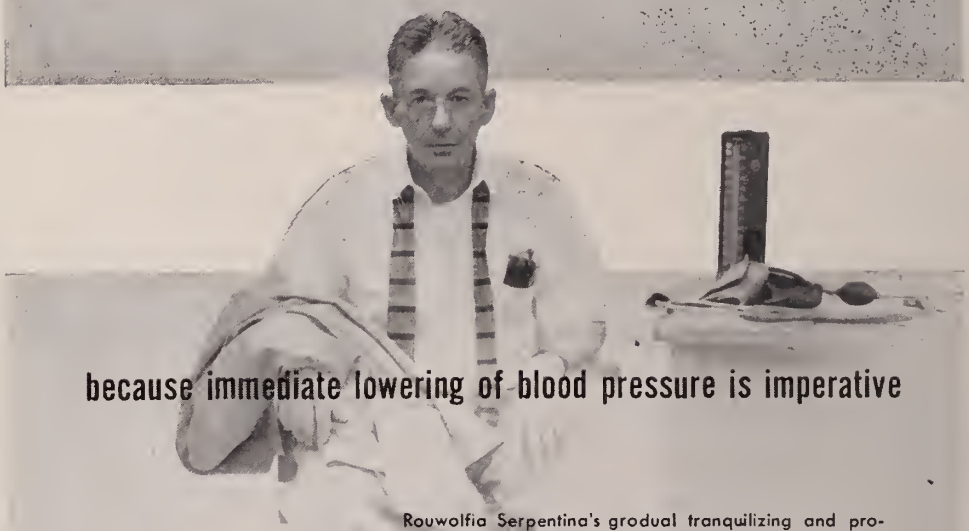
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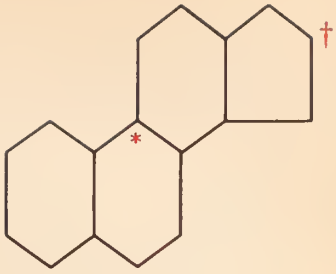
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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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Lederle

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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1. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957. 2. Hartung, E. F.: Paper presented at Florida Academy of General Practice, St. Petersburg, Florida, Nov. 2, 1957.

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The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Schwartz, E.: Personal Communication. 4. Spies, T. D.: Personal Communication. 5. Barach, A. L.: Personal Communication. 6. Segal, M. S.: Personal Communication.

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The Promise of Aristocort

in Nephrotic Syndrome

◊ *Fourteen patients with the nephrotic syndrome have been treated with* ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

◊ *Eleven patients with pulmonary emphysema and/or fibrosis were treated with* ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

◊ *Forty-four children and adults have been given* ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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CHRONIC BLOOD LOSS:

"...this patient did not receive any transfusion of blood or any hematinic other than the intramuscular dose of iron. His initial concentration of hemoglobin measured 5.8 gm. per 100 cc. of blood and in spite of operation [hemorrhoidectomy] and further loss of blood the concentration increased to 12.2 gm. within less than 3 weeks. Concomitantly with the hematologic improvement there was clinical improvement and subsidence of the initial primary symptoms [unusual fatigability, dyspnea, palpitation on exertion]."[1]

INTOLERANCE TO ORAL IRON:

"...she had an excellent response with a reticulocyte peak of 5.3 per cent on the seventh day, and a complete disappearance of the anemia and conversion from hypochromic to normochromic cells by the end of two months. She experienced remarkable improvement in pep and sense of well-being coincident with the alleviation of her anemia."[2]

(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

Supplied: 2-cc. and 5-cc. ampuls, boxes of 4. Physician's directions in every box. There are 50 mg. of elemental iron per cc. Request brochure NDA 17, Imferon.

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Which plasma proteins may be hazardous in renal disease?



The globulins. They are more easily precipitated to form casts with blockage of renal tubules. The greater the damage to the glomeruli, the greater the proportion of urinary globulin to albumin and subsequent tubular impairment.

Source—Hoffman, W. S.: The Biochemistry of Clinical Medicine, Chicago, The Year Book Publishers, Inc., 1954, p. 233.

colorimetric "dip-and-read" test for proteinuria

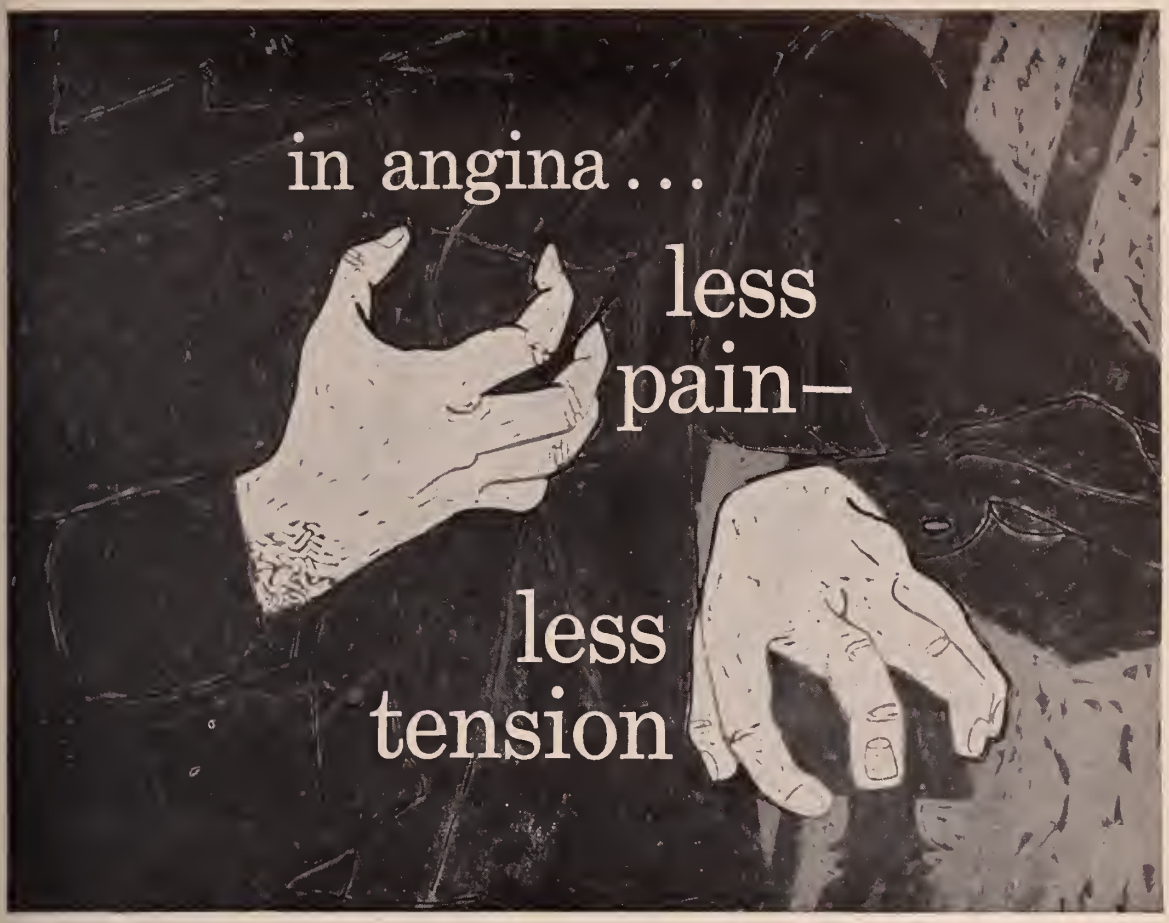
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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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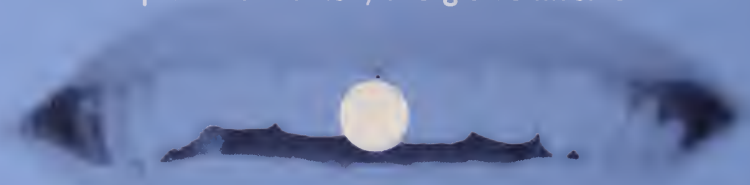
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*Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. *23*:41 (Jan.) 1958.

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1. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. *6*:580 (April) 1955.
2. Codling, J. W., and Lowden, R. J.: Northwest Med. *57*:331 (March) 1958.



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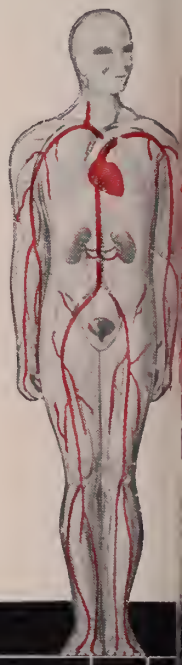
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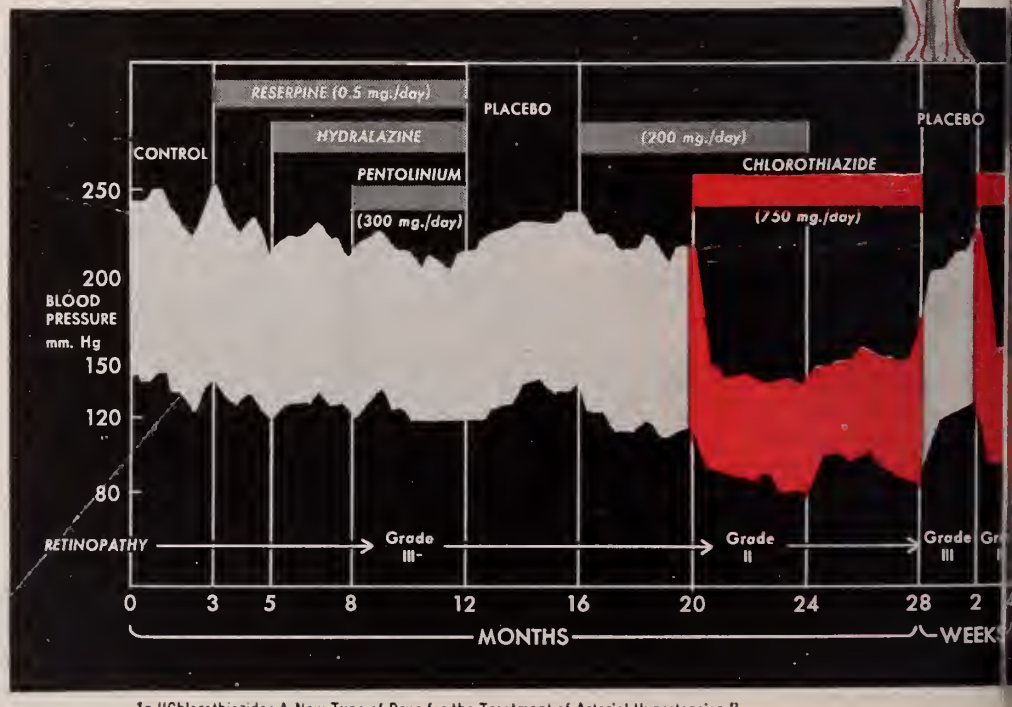
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, Septembe

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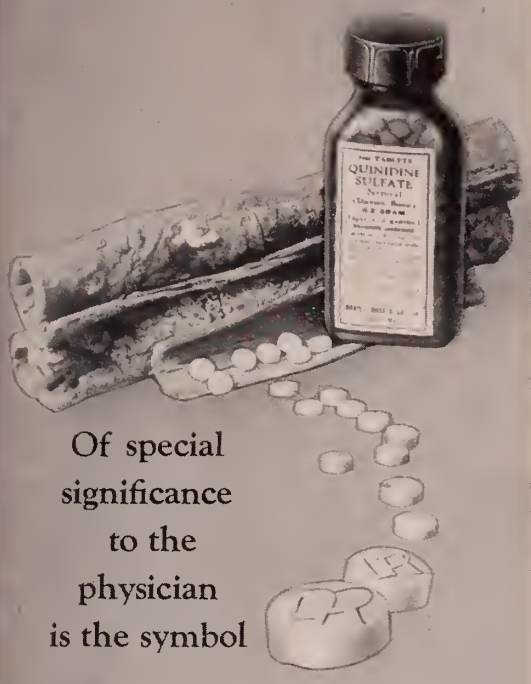
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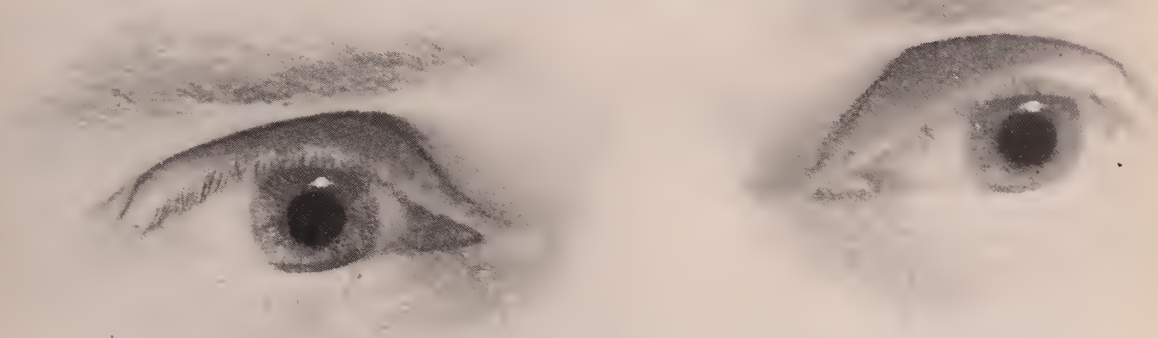
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*Howell, C. M., Jr.: Am. Pract. & Digest Treat. 8:1928, 1957.

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1. Grossmann, E. E., and Lehman, R. H.: Am. J. Ophth. 42:121, 1956.

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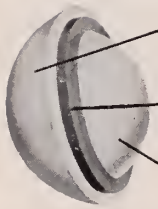
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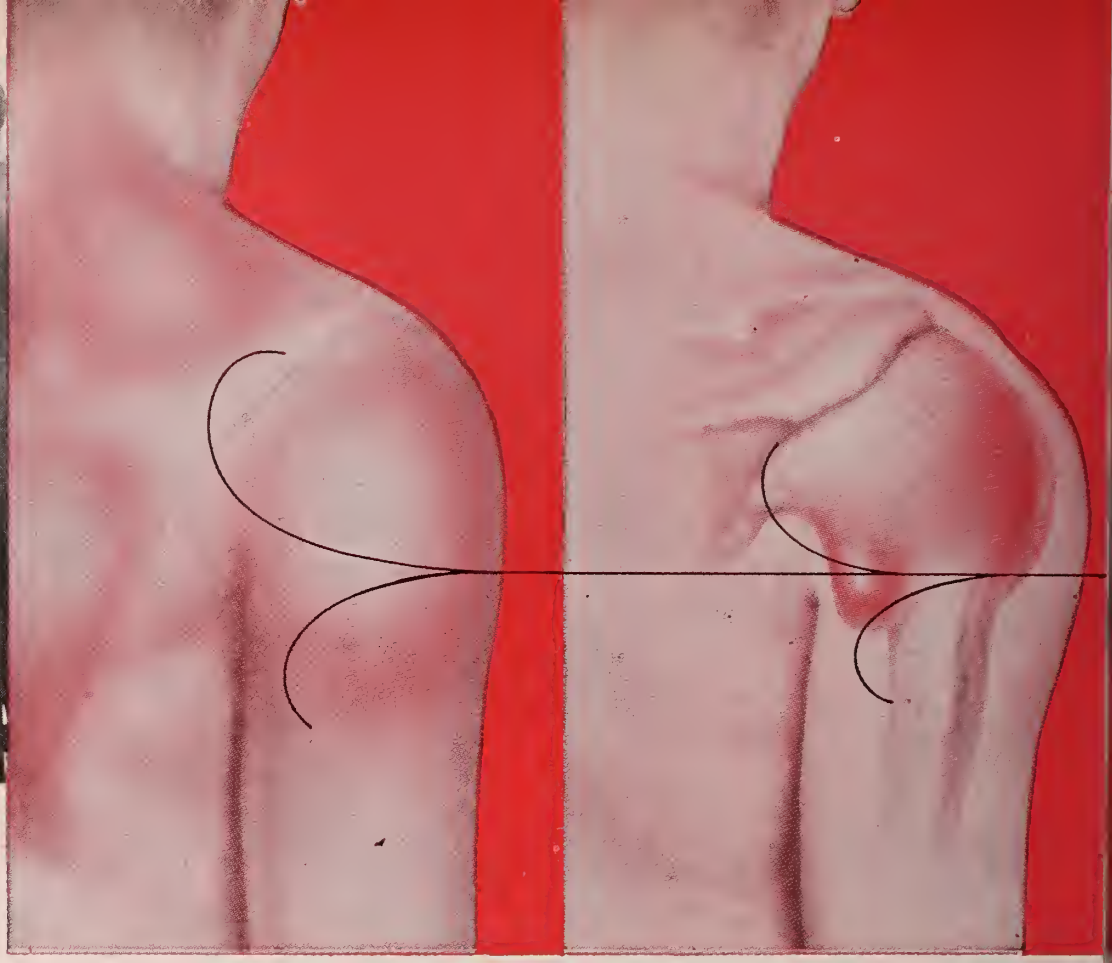
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rheumatoid arthritis involves both joints and muscles only

MEPROLONE is the only anti-rheumatic-antiarthritic designed to relieve simultaneously (a) muscle spasm (b) joint-muscle inflammation (c) physical distress . . . and may thereby help prevent deformity and disability in more arthritic patients to a greater degree than ever before.

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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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relieves both muscle spasm and joint inflammation

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"Excellent,"[5] "marked,"[1] "pronounced"[2] or "significant"[6] results in 75.3% of cases of acute skeletal muscle spasm, and moderate results in 20.3%—or an over-all beneficial response in 95.6%. Other important advantages:

- **Highly potent and long acting.**[2,3,4,6,7,8]
- **Relatively free of adverse side effects.**[1,2,3,6]
- **In ordinary dosage does not reduce normal muscle strength or reflex activity.**[6]

Summary of four published clinic

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CONDITION
STUDY 1[1] Skeletal muscle spasm secondary to acute trauma
STUDY 2[2] Herniated disc Ligamentous strains Torticollis Whiplash injury Contusions, fractures, and muscle soreness due to accidents
STUDY 3[5] Herniated disc Acute fibromyositis Torticollis
STUDY 4[6] Pyramidal tract and acute myalgic disorders
TOTALS



TE SKELETAL MUSCLE SPASM[1,2,5,6]

	RESPONSE		
	moderate	*slight*	*none*
ed"	6	1	—
nced"	13	—	1
	4	—	—
	—	—	—
	1	—	—
	2	—	—
ent"	2	—	—
	—	—	—
	—	1	—
ant"	—	2	1
	28	4	2

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"In the author's clinical experience, methocarbamo has afforded greater relief of muscle spasm and pai for a longer period of time without undesirable sid effects or toxic reactions than any other commonl used relaxants . . ."[2]

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"An excellent result, following methocarbamol ad ministration, was obtained in all patients with acut skeletal muscle spasm."[5]

THE JOURNAL of the American Medical Association

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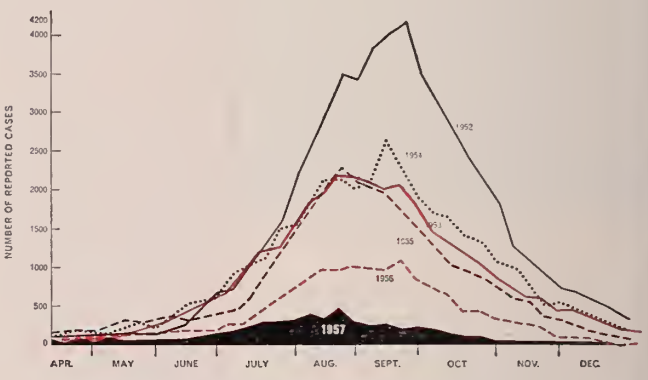
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Robins

A MIRACLE IN OUR TIME?

At the last accounting,[1] physicians throughout the country had administered at least one dose of poliomyelitis vaccine to 64 million Americans—all three doses to an estimated 34 million. Undoubtedly, these inoculations have played a major part in the dramatic reduction of paralytic poliomyelitis in this country.



Incidence of polio in the United States, 1952-1957
(data compiled from U.S.P.H.S. reports)

vaccine is plentiful for the job remaining

There are still more than 45 million Americans under forty who have received no vaccine at all and many more who have taken only one or two doses.

As it was phrased in a public statement by the Department of Health, Education, and Welfare:

> *"It will be a tragedy if, simply because of public apathy, vaccine which might prevent paralysis or even death lies on the shelf unused."*[2]

Eli Lilly and Company is prepared to assist you and your local medical society to reach those individuals who still lack full protection. *For information see your Lilly representative.*

1. *J. A. M. A.*, 165:21 (*November 23*), *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*



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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Here's Ken Gardner



This year's number one man in New Jersey medicine is Kenneth Earl Gardner. Dr. Gardner is a general practitioner—and proud of it! He was born in 1903 and won a B.S. degree at Bucknell. He entered the medical school of the University of Pennsylvania in 1926, and was graduated in 1930. He won one of the coveted "Blockley" internships: appointment as a house officer at the Philadelphia General Hospital. After 2 years there, he looked for further training in chest diseases—and that is what brought Ken Gardner to New Jersey. He became a resident at the Essex County Sanatorium in Verona. In 1935 he entered private practice in Bloomfield, and he has been serving the people of Essex County ever since.

Ken Gardner is an "attending" in general practice at the Mountainside Hospital. He is a Fellow of the American College of Chest Physicians. He has served on the Judicial Council of our society, and since 1952 has been president of the Essex County Blood Bank. He is also a good citizen and a good

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neighbor. He is a member of the Essex County Welfare Board, a Shriner and a talented composer of and an appreciative lover of good music. Travel and photography are other hobbies.

He has served The Medical Society of New Jersey in many capacities, and became president-elect last May. On April 18, 1958, he was catapulted into the Presidency of the Society to fill the gap left vacant by the tragic and untimely death of Albert Kump. Last month he was installed, in his right, to begin his regular term at the helm of this Society.

Man's Oldest Food

No man began life without milk. No food is mentioned more frequently—or more pleasantly—in the Bible. If there is an elixir of life, it is surely milk. It comes from the young, destined generally for the younger; so its flow is a veritable fountain of youth. It works its way into our folklore—for Jerusalem the golden was "with milk and honey blest." It is praise to say that one has a generous measure of the "milk of human kindness." Ovid spoke of *flumina lactis, flumina nectaris*—rivers of milk (that food for mankind) and rivers of nectar (that food of the gods). The epitome of futility is crying over spilt milk. And the epitome of beauty and daintiness is the milkmaid . . . and we all know where she is going, pretty maid.

Milk is the nearly perfect food—as it must be to serve its primary purpose. For the adult it is the best storehouse of calcium and a compact source of vitamins. And it supplies more of that life-giver, water, than any other common food.

To the physiologist, it is the end product of the most complex and highly interlocked of all glandular processes. It seems as if every endocrine in the body conspires to produce milk at just the right time—and turn off the flow at the right time.

Milk has become an important article of commerce, supporting millions of farmers, truckers, bottlers and processors. It is the source of butter, cream and cheese. It is a symbol of progress and prosperity, for impoverished lands must cut down on milk consumption. Milk is the prime ingredient in the great American dessert which has now found its way around the world.

Milk was the first of the foods to be subject to government regulation. And even the most ardent individualist agrees that such regulation is necessary in the interests of our children.

Scientists have devoted attention to the technics of preserving and enriching milk. In 1810, Nichole Appert won the French Imperial Prize for having discovered some of the principles of canning and preserving milk. Apparently Appert discovered that boiling was the first step—though in 1810 he could not have know that it was the office of boiling to destroy the bacteria in the milk.

Time was when cows were dirty, milk preparation was unsanitary and milk retailing was crude and unhygienic. One of the earliest and most effective of the public health programs was the insistence on clean milk preparation. We in New Jersey have special cause for pride, since it was in our state that Henry Leber Coit first developed certified milk.

For decades, milk was dismissed by he-men as food fit only for babes. Such phrases as "milksop" reflected this attitude. But many a he-man soldier will recall how gratefully he accepted good milk on his return to the states. Having had no whole milk at all—or only a sickly powdered milk—on foreign duty, he received his first glass of milk here with gratitude and enjoyment.

Milk is a symbol of the good, the prosperous, the nutritious. It could be that Elsie the cow may become a national emblem. We could do a lot worse.

$CH_3COOC_6H_4COOH$

Just sixty years ago this month, a German chemist by the name of Otto Dreser tried to develop a form of salicylic acid that would pass untouched through the stomach and be released in the intestines. This was part of the search for the European equivalent of the cinchona bark. Quinine had proved itself a wonderful antipyretic, but cinchona could not be grown in Europe. The most heralded European antipyretic bark was that which came from the willow.

The willow, of the genus *Salix* already had a secure place in European mores. It was associated with mood changes—were there not weeping willows? It was used in basketry, and in tanning. The word "sallow" (suggested by the yellowish color of *Salix*, the willow) meant unhealthy looking. But best of all, the bark of *Salix* could reduce fevers.

The bark of the willow contained an ingredient called, at first, spireic acid. The chemists insisted, though, that the proper name was acid salicylic for it came from *Salix*. And that was where Herr Dreser came in. He took this acid spireic and acetylated it. The new preparation, having been made from acid spireic, he baptized "aspirin" thus neatly compressing the two words—acid, spireic. Chemical purists insisted, of course, that it be called acetyl salicylic acid.

And thus there was introduced, within the life-time of many of us, the most popular pharmaceutical of all time. Of course, right now, tranquilizers are selling like hot cakes, antibiotics are being dispensed in vast quantities, vitamins are still sold by the million; but Herr Dreser's aspirin outsells them all. In 1957, the American people bought 12 million pounds of it. Since there are 1536 tablets in a pound, we must be swallowing 18 billion aspirin tablets annually, or about 125 tablets a year for each man, woman and child in the U.S.A.

It is possible to commit suicide with aspirin, but it takes about 100 tablets swallowed in quick succession, to do it. And children or salicylate-sensitive people can suffer ill effects. But so far, there has never been reported an adult death due to a therapeutic dose of aspirin. It is thus one of the safest medications in our pharmacopeia.

And what a versatile drug it is! It is antipyretic, antirheumatic and antiphlogistic. It combines with many other drugs to form valuable double-barreled medications. It is useful in toothache, headache, and chorea. It increases the flow of bile, relieves itching, flushes out uric acid. It is rapidly and readily absorbable in the gastro-intestinal tract. It lowers both the pulse rate and the sedimentation rate. It is an antidiabetic agent, correcting hyperglycemia and ketosis, and relieving thirst, polyuria and diabetic pruritus.* It is as useful in the common cold as many a more expensive remedy—for aspirin is the most modestly priced of all wonder drugs.

No doctor's bag is complete without it. It is found in every medicine chest in the land—whether that medicine chest be in an army post, a children's camp, a city hospital or a private home.

So, greetings to the genius of the genus *Salix*, the priceless ingredient of the willow, the soothing, pain-relieving, non-addicting, inexpensive boon to mankind, $CH_3COOC_6H_4COOH$.

*See editorial in March 1958 *Canadian Medical Association Journal.*

The Role of Insurance in Meeting the Costs of Medical Care

II. The Customary Forms of Protection

By the Joint Conference Committees of The Medical Society of New Jersey and the Health Insurance Council*

During the past two decades, voluntary health insurance has been a growing factor in the financing of health care. The accomplishments and potentials of such insurance are of concern to all physicians. The Joint Conference Committees of The Medical Society of New Jersey and the Health Insurance Council are sponsoring a series of three articles on the fundamentals of health insurance and the types of protection available.*

Our initial article furnished basic information about the concepts and methods of voluntary health insurance. This article deals with the contribution made by the customary forms of health insurance. The final article will discuss major medical expense insurance and its promise for the future.

Before the development of major medical expense insurance, voluntary health insurance was commonly divided into four branches on a basis of the hazard insured against: protection against loss of income because of accident or illness, protection against hospital expense, protection against surgical expense, and protection against regular medical expense. A few types of policies do not fit readily into any of the four categories.

LOSS OF INCOME

The earliest form of health insurance was protection against loss of income because of disability. Without some provision for the continuation of income during disability, many breadwinners would find it difficult to meet daily expenses. While income continues there is some possibility of meeting the expenses resulting from the accident or illness.

Since the middle of the nineteenth century, insurance companies have been offering individual policies providing periodic cash benefits in replacement of lost earnings if the insured person is unable to work because of illness or injury. For the past thirty years they have been offering the same protection through group policies. Obviously, loss-of-income benefits can ordinarily be provided only for gainfully occupied persons.

Income benefits under individual health insurance policies usually begin a week or two after the onset of the disability and may have a maximum duration of one or two years. How-

*Dr. Daniel F. Featherston is Chairman of the Medical Society's Committee. Other members are Dr. F. Clyde Bowers, Dr. Marcus H. Greifinger, Dr. J. Wallace Hurff, Dr. Jesse McCall, Dr. Royal A. Schaaf, Dr. Rudolph Schretzmann, and Mr. Richard I. Nevin, Executive Officer of the Society. Dr. Berthold T. D. Schwarz, Vice-President and Medical Director, Bankers National Life Insurance Company, and Dr. F. Irving Ganot, Medical Director, The Prudential Insurance Company of America, are among the members of the Health Insurance Council's Committee, which is under the chairmanship of Mr. Ardell T. Everett, Second Vice-President, The Prudential Insurance Company of America.

ever, policies are available providing benefits for five or ten years or more for any one illness. These more liberal policies often specify a waiting period of one to three months before benefits commence. Lifetime benefits during disability caused by accident are not uncommon.

Waiting periods of one or more weeks are fairly common and often can be as long as 12 months. The waiting period for disability due to sickness is often the same as that applying to disability due to accident, although there are many instances where the waiting period for disability due to accident is shorter than the waiting period applying to sickness. In some instances there may be no waiting period at all with respect to disability due to accident but the complete absence of a waiting period applying to sickness disability is extremely rare.

The use of waiting periods greatly reduces the cost of insurance by eliminating entirely the many short disabilities for which benefits would otherwise be payable and which do not ordinarily cause the insured a severe economic hardship. Waiting periods, particularly those of longer durations, also permit the dovetailing of income protection insurance with other income protection insurance or with other plans such as salary continuance programs.

The duration of income protection benefits varies greatly, with some policies providing maximum durations of one to five or ten years. Lifetime benefits during disability caused by accident are not uncommon. More recently, income protection policies have been devised that provide for duration of benefits up to age 65 which would be the normal retirement age under current business practice.

In both group and individual insurance, the waiting period may apply only to disability resulting from illness, with immediate benefits for disability caused by accident. Or the waiting period for accident benefits may be shorter than that for illness benefits. A reasonable relationship between policy payments and normal earnings must be maintained.

HOSPITAL EXPENSE PROTECTION

Preliminary steps in the growth and development of insurance against hospital expenses were taken in the early 1900's, when some insurance companies wrote provisions in their loss-of-income policies whereby the weekly benefit amount was increased during any period the individual was in a hospital.

While the extra benefits payable under the early policy forms usually amounted to only a few dollars a day, such amounts were of real help at a time when a private room in a hospital could be obtained at a daily rate of $5.

With the emergence of Blue Cross in the 1930's, hospital expense protection assumed a greater importance. Influenced by the competition of Blue Cross, insurance companies commenced broadening their hospital benefits, and providing them in separate policies as well as in connection with loss-of-income benefits. At present, both individual and group insurance protection against hospital charges are very popular and widely available, not only to the gainfully employed but also to their dependents, to students and to other groups. More people have hospital expense protection than any other kind of accident or sickness insurance.

Modern policy provisions protecting against hospital expense usually offer benefits toward meeting both the hospital's room and board charges and the charges for other hospital services. Physicians' charges for services such as anesthesiology and radiology are often included also.

Daily room-and-board benefits offered in individual policies range from about $3 to $20. These benefits are now generally payable for a maximum of 60, 90, 100, or even 365 days.

Group policies ordinarily provide similar daily hospital benefits, usually for up to 31 or 70 days, with durations up to two years available. The miscellaneous hospital expense benefits of group policies now range from five times the daily benefit to very much larger amounts. In fact, the miscellaneous hospital expense benefits in some group policies are virtually unlimited, which is particularly helpful for patients who require extensive use of costly medical equipment or expensive drugs.

Some group policies issued by insurance companies instead of specifying a dollar limit, provide full payment for semi-private room and board accommodations, up to a time limit such as 120 days, plus all miscellaneous hospital expenses during that period.

In Blue Cross plans, a diversity of benefit provisions is found. Full payment for room and board in semi-private accommodations is usually provided for varying days, with a 30-day provision the most common. Following the expiration of the full-payment period, the Blue Cross subscriber is often entitled to a period of partial- or half-benefit days, the partial-benefit period most frequently being 90 days.

SURGICAL EXPENSE PROTECTION

As with hospital benefits, policy provisions protecting against the costs of surgery can be traced back to the early 1900's. At that time some loss-of-income policies were broadened to include a schedule of benefit amounts to be paid in reimbursement of the costs of specified surgical procedures.

The effective development of surgical expense insurance, however, began in 1939, when such protection was first made available apart from loss-of-income coverage. Protection is usually extended to the dependents of the primarily insured persons.

Insurance contracts offering surgical expense benefits usually contain a schedule listing the amount the company will pay in specified surgical procedures. For any operation not on the schedule, the contracts usually provide that a benefit will be paid in an amount consistent with the sums that are listed. In both individual policies and group insurance the maximum sum listed, formerly often $100, now generally ranges from $200 up to $500.

Blue Shield contracts are generally similar to the surgical expense policies of insurance companies, except that the participating physicians usually agree to accept the specified sum as full payment for the service rendered, provided the subscriber's income does not exceed a specified amount. At higher income levels, cash benefits are usually paid. As with insurance-company benefits, such cash benefits may be assigned and paid to the physician.

MEDICAL EXPENSE PROTECTION

The popularity of surgical expense insurance inspired insurance companies and Blue Shield plans to offer protection against non-surgical medical expense, often through extension of a surgical insurance contract. Effective development in this field began about 1944. As in hospital and surgical expense insurance, protection is usually available to dependents of the primarily insured persons.

Regular medical expense protection should not be confused with major medical expense protection, the broad new form of voluntary health insurance which will be discussed in the concluding article. Regular medical expense protection, generally speaking, provides benefits only with respect to the cost of the doctors' visits for non-surgical care. Major medical expense protection, in contrast, ordinarily provides benefits toward meeting almost all types of expense for the treatment of unusually costly or long-lasting illnesses.

Three types of physicians' calls are distinguished in regular medical expense insurance. in-hospital calls, home calls, and office calls. Many families prefer to budget against the cost of home calls and office calls, where the illness or injury is usually less serious, and to insure only against the cost of in-hospital calls. Consequently, much regular medical expense protection is on an in-hospital basis. However, comprehensive protection is also available, including benefits not only for hospital, home, and office calls but also, in some cases, for the cost of x-ray, laboratory, and special diagnostic examinations.

Typically, $5 is provided for home calls in insurance-company policies, and $3 for office or hospital calls, although there is considerable variation in the amounts provided. Often the first three calls are excluded for benefit purposes, and a maximum limit is placed on the total payments during any one period of disability. Similar benefits for regular medical ex-

pense are provided by Blue Shield plans, with full-payment arrangements similar to those in Blue Shield's surgical expense protection.

GROWTH TRENDS IN HEALTH INSURANCE

THERE has been a remarkable growth in the numbers having hospital, surgical and regular medical expense protection over the past twenty years. Since 1941, the number of persons with hospital expense protection has increased tenfold, reaching 123 million by the end of 1957. For surgical expense protection, the number of persons with coverage has multiplied more than twenty times, to 109 million by the end of 1957. Regular medical expense protection was still in an experimental stage in the early forties, and the number covered increased slowly from about 3,000,000 at the end of 1940 to 3,840,000 at the beginning of 1945. In the thirteen succeeding years, however, the number has multiplied by more than nineteen, reaching 74 million by the end of 1957.

OTHER FORMS OF PROTECTION

IN ADDITION to the types of voluntary health insurance discussed above, a number of other forms of protection against expenses of accidents and illnesses are available.

Nursing expense is covered in many individual policies of the types previously considered. "Dread disease" policies provide comprehensive protection against the costs of certain specified illnesses. Accident insurance provides protection against the cost of all accidents, or, in specialized policies, of travel accidents only.

Life insurance often includes disability income benefits. Also, one of the important purposes served by life insurance is to provide a "clean-up" fund to meet such bills as those of the insured person's final illness.

Liability insurance of all kinds provides hospital and medical benefits and recompense for lost earnings when the insured person is liable for the damages suffered by the injured person. Many liability policies, in fact, provide hospital and medical benefits for individuals injured in the insured person's car or on his premises, without regard to the insured person's liability for the accident.

Workmen's compensation insurance protects workers against hospital and medical expense and income loss due to occupational accident or disease.

Five programs providing cash benefits in case of lost income due to sickness or disability have been established by compulsory legislation. In three of these programs, including the one in New Jersey, employers may provide the required benefits through private insurance instead of through the government fund.

Government, at either the national or the state level, has assumed complete or partial responsibility for the medical care of persons in the armed forces and their dependents, veterans, Indians, and persons in government sanatoriums, prisons, and other public institutions.

HEALTH INSURANCE IS COOPERATIVE

HEALTH insurance does not operate in a vacuum. It is affected by the other types of protection available and, even more, by the "state of the arts." Policies must take account of the actual practices and charges of physicians and hospitals. Policies must be attractive to the insuring public and must be provided at prices people are able and willing to pay. In group insurance, the desires of the employees and the employer as to the nature and scope of employee welfare program are of determining importance.

Progress in voluntary health insurance is not solely up to the organizations that issue it. While they, of course, bear primary responsibility for progress, future successes will depend in large measure upon the development of increasingly high levels of cooperation among the various interested groups.

The most important future task of the insuring organizations is to continue to expand,

as rapidly as possible, the numbers having health insurance protection and to increase the adequacy and scope of the benefits furnished. Also, with health insurance increasingly recognized as a necessity, the insuring organizations must seek in every way to provide it at the lowest possible cost consistent with sound practices.

The achievements of modern medicine have undoubtedly contributed indirectly to the growing demand for health insurance. Insurance companies as well as the community at large should actively support medical progress. For their part, physicians and hospitals can further the progress of health insurance by cooperating on equal terms with all reputable insuring organizations, thus helping to preserve the free competition which has been so largely responsible for the past progress of health insurance.

Another point concerns the role of insurance in bringing together the relatively small premiums of numerous insured persons, with the accumulated funds being used to pay benefits to those stricken by the hazard insured against. In other words, the insurance merely redistributes the funds of those insured; it does not increase the funds. On the contrary, the insurance actually reduces the funds somewhat by the necessary administrative costs of the insurance operation. Consequently, there is no reason for those with insurance to be charged more than those without insurance. If those with insurance, who have been prudent enough to try to provide for their health expenses through the advance payment of premiums, should in the end have to pay more for medical service than if without insurance, then the effect would be to penalize for their foresight those who insure.

Employers have contributed much to the development of health insurance by providing group insurance to their employees and by paying some or all of the premiums. The future growth of employee welfare plans in both numbers covered and benefits provided can be anticipated with confidence. Moreover, employers can be of great help in combating any abuses of health insurance through their knowledge of individual circumstances. In many cases, they are better able than either the doctor or the insurance company to distinguish between a bona fide and a needless claim for benefits.

The insuring public has learned a great deal in recent years about the benefits of health insurance. However, the average family could still acquire or exercise greater wisdom in the purchase of health insurance, learning to select accurately the policy that best fits the family's needs. Similarly, families might desirably budget toward meeting their health expenses more than they ordinarily do at present. A special savings account of as little as $100 could be of great value to the average family in eliminating any need for insurance against trivial items, thereby enabling the family's premium dollar to go much farther toward providing protection against the more serious and more expensive illnesses.

Hospital Assets

Of more than $500 million spent on private hospital construction in the U. S. last year, an estimated three-fifths came in the form of voluntary contributions, Health Information Foundation reports.

Private nonprofit hospitals in this country have an average of more than $14,000 in assets per bed, according to Health Information Foundation. Comparable figures are $10,000 for federal hospitals; $5,000 for nonfederal government hospitals; and $4,300 for proprietary hospitals.

Emil G. Piserchia, M.D.

Elizabeth

Promethazine* As a Pre-Anesthetic

The normal person does not anticipate surgery without tension and one way of reducing such apprehension is pre-anesthetic medication. A simple pre-anesthetic procedure is here described.

Fear is the natural human reaction to the prospect of surgery. Patients who come to anesthesia in a "normal" state of awareness are usually inwardly apprehensive, however calm they may try to appear. Those who are obviously excited or nervous before induction are liable to experience some form of delirium during emergence. Many drugs have been introduced for control of pre-anesthetic tension. Some have yielded a measure of effectiveness,[1] but until recently none have provided the state of quiescence[2] so desirable in the immediate pre-operative period without causing undue depression of the vital functions.

Evidence so far accumulated on the diverse pharmacologic properties of the phenothiazines has led to a number[1,2,3,4,5] of clinical investigations of the sedative, anti-emetic, atropine-like, and narcotic- and anesthetic-potentiating activities of promethazine.* In the synthesis of this compound, a dimethyl amino isopropyl group is added to the phenothiazine nucleus. Its molecule possesses a branched rather than a straight side chain. This is believed to be largely responsible for the absence of the hepatotoxic and other side actions produced in some patients by certain other compounds of the phenothiazine series, notably chlorpromazine.[6] We were therefore led to study promethazine in the hope of developing a safer method for pre-anesthetic sedation than the routine measures formerly used, which included the barbiturates, meperidine or other narcotics, atropine or scopolamine.

Throughout the period of investigation we used promethazine* as part of the pre-anesthetic medication for 382 consecutive, unselected patients (68 per cent females, 32 per cent males), who underwent a wide variety of operations.

Blood pressure, pulse and respiratory rate were recorded in the afternoon or evening before operation, and again the next morning, immediately before induction.

Desage. The pre-anesthetic dose varied according to the age, body weight and physical status of the patient, and the nature of the operation. Forty-three per cent of the series (165 patients) received 50 milligrams of promethazine,* 50 milligrams of meperidine and 0.4 milligrams (1/150 grain) scopolamine. These drugs were added to the syringe in the order named and administered intramuscularly in one dose.

*Available as Phenergan®, Wyeth Laboratories.

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Forty-four of the 50 children on whom tonsillectomy was to be done received promethazine* in suppository form, and atropine by intramuscular injection. Each of 12 children (weighing 40 pounds or more) received a rectal suppository containing 25 milligrams of promethazine*; and 32 (weighing less than 40 pounds) received 12.5 milligrams in the same form. The remaining 6 children (all 5 years old) received 20 milligrams of promethazine* and 0.3 milligrams of atropine intramuscularly. For all of this group, the pre-anesthetic medication was administered an hour before induction.

Of the remaining 332 patients, 7 received the pre-anesthetic dose ten to twenty minutes before induction; 22, one-half hour; 32, three-quarters of an hour; 258, about one to one and three-quarters hours; 9, two hours, and 4 two and one-half hours before administration of the anesthetic.

Anesthesia. General anesthesia was used for 77 per cent of the group. General anesthesia was given to all patients on whom operations were to be done upon (a) the face, head, neck and throat (including tonsillectomy), (b) lung and heart, (c) stomach, (d) small intestine; (e) extremities, (f) blood vessels; and (g) dilatation and curettage.

Twenty-three per cent were operated upon under spinal anesthesia. These included about half of those upon whom cholecystectomy and gynecologic procedures were carried out, and most of those with operations upon the rectum, anus, other areas of the large intestine, the genitourinary tract, and hernias. All patients having operations for pilonidal cysts received spinal anesthesia.

RESULTS

THE important finding in this study was that no significant disturbance of blood pressure, pulse or respiratory rate occurred as a result of the pre-anesthetic medication. In 18 per cent there was no change and in 79 per cent only insignificant fall or rise (10 millimeters or less) in *systolic pressure*. In 3 per cent (patients who had been hypertensive at the time of the pre-operative blood pressure determination) a fall of 14 to 20 millimeters occurred, but the diastolic pressure remained within normal limits. The *pulse rate* was unchanged in 7 per cent and in 93 per cent showed an insignificant deviation (fall or rise of 2 to 14) which was not correlated with blood pressure alterations. No change in *respiratory rate* occurred in 68 per cent; 32 per cent showed a trivial variation of 2 to 6 respirations per minute, plus or minus.

Barbiturates were eliminated from the preoperative regimen. The total amount of narcotics required in the pre- and postoperative periods was reduced to half the dosage formerly used, and the requirement of amnesic and drying agents was lessened. Thirty-one per cent of this series required 0.3 milligrams, and some only 0.25 milligrams of scopolamine, or 0.3 milligrams of atropine. For the younger children, 0.15 milligrams of atropine sufficed. In the 9 patients who received no scopolamine or atropine, the drying (atropine-like) effect of the promethazine* alone was fairly adequate, but was less prolonged, and an additional injection of 25 milligrams of promethazine* was required during operation.

The total amount of anesthetic agents also was significantly reduced in the majority of cases, particularly the intravenous dosage of thiopental sodium. Emergence was smooth for practically all patients.

The sedative properties of promethazine* were demonstrated in this series. Eighty-four per cent of the patients came to anesthesia in a satisfactorily quiescent state. They were not apprehensive, appeared undisturbed by the environment of the surgical suite, and took no notice of the usual manipulations in preparation for anesthesia. Some appeared to be in a light sleep; others merely lay quietly and showed no interest in their surroundings. All of this group, however, could be easily aroused, responded rationally to questions, then lapsed again into the quiescent state.

Inadequate sedation. Sixteen per cent were inadequately sedated. Sedation failed in all of the patients who received the medication less than one-half hour before induction; and in

24 per cent of those brought to anesthesia one-half to three-quarters of an hour after the injection. Of the 13 who had received the medication two to two and one-half hours before induction, with adequate initial effect, only one showed apprehension on reaching the operating room, indicating that sedation had worn off.

A variety of factors may influence the efficacy of any pre-anesthetic medication. One or more no doubt contributed to each failure in this series. For example, it is important to allow an appropriate length of *time* for development of the full sedative effect before transport of the patient to the operating room. This movement in itself is usually an emotionally traumatizing experience to the normally conscious individual.

Sex, age, physical condition and the presence of unusually *disturbing external influences* also may play a role in the failure of the pre-anesthetic sedative. Female patients are generally more inclined to "nervousness" and excitability than males. Forty-six of the 61 patients in this series who came to operation in an apprehensive state were females, 15 were males (a ratio of 3 to 1).

Of the 308 who received the medication one to one and three-quarters hours before induction (the optimum interval) 13 per cent were inadequately sedated. Most of these were about 60 years of age or older. In addition, one patient in this group had parkinsonism, seven advanced cancer, and one had a thyroid tumor.

Inadequate pre-anesthetic sedation in 14 per cent of the children admitted for tonsillectomy is a moderate incidence when the circumstances are considered. None had received any type of sedative before leaving home on the morning of operation. All had been active (and probably reluctant to come to the hospital). On arrival, all had been obliged to await attention for varying lengths of time, during which they were exposed to many unfamiliar and disquieting sights and sounds. However, despite such undesirable influences, 86 per cent of the children came to the operating room in a quiescent condition.

Since candidates for tonsillectomy are usually admitted, operated upon and discharged the same day, it may be desirable to provide each with a promethazine* suppository, to be administered at home before leaving for the hospital.

No vomiting occurred before or during operation in any of the patients in this series.

On emergence all patients were questioned as to how much they remembered of the environment of the surgical suite. Very few had any recollection at all of the pre-anesthetic experience, an important feature of pre-operative management.

SUMMARY

1. A consecutive series of 382 unselected patients of all ages were subjected to a wide variety of operations. This included 50 children on whom tonsillectomy was performed.

2. Pre-anesthetic medication consisted of promethazine,* with or without meperidine and scopolamine or atropine, administered in varying dosages, ten minutes to two and one-half hours before induction.

3. Forty-four of the 50 children submitted to tonsillectomy received the promethazine* in rectal suppositories.

4. No barbiturates were used in the pre-operative period; about one-half the dosage of narcotics, smaller doses of amnesic and drying agents, and, it is believed, less anesthesia, especially thiopental sodium, sufficed for the majority. There was no adverse influence on vital functions; *i.e.*, no significant depression of blood pressure, pulse and respiratory rate attributable to the pre-anesthetic regimen. The systolic pressure showed no change in 18 per cent, and remained within normal limits for all others.

5. Eighty-four per cent of the total series (86 per cent of the tonsillectomized children) were satisfactorily sedated. It is important to allow an appropriate interval for development of the peak quiescent effect; if operation is too long delayed thereafter, quiescence will wear off. The sex, age and physical condition of the patient, as well as the presence of severely

disturbing external influences may play a role in the failure of pre-anesthetic medication.

6. Administration of a promethazine* rectal suppository at home before leaving for the hospital is recommended for children to be subjected to tonsillectomy, who are admitted, operated upon and discharged the same day. Such pre-operative medication will render the patient less susceptible to disturbing external stimuli, and reinforce the pre-anesthetic dose.

Thanks are due Dr. W. R. Finnegan and the Anesthesiology Department at the Elizabeth (N.J.) General Hospital for their help in this study.

ADDENDUM

Since submission of this paper, one thousand additional patients have received the same pre-anesthetic medication, with substantially the same results as above described.

925 East Jersey Street

Teaching Patients To Leave Pimples Alone

Analyzing 96 adolescents with acne, Gaul* describes the effect of picking, squeezing and other fondling of the skin. Such acts produce keloidal tumors.

Patients admitted fondling, rubbing and excoriating the skin, gouging and picking. Squeezing and "mirror practices" were reported by most patients.

Sixty cases, including 42 girls were scarred to varying degrees from squeezing with fingernails, needles or bobbie pins. "Every patient who had an acne of long duration manipulated the affected areas. They never finished because the injury produced new lesions, and thus the activity goes on interminably. Scarring is the final outcome, and the same holds true for adolescent acne unless the fallacy is exposed."

*Gaul, L. E.: Indiana Medical Association Journal, 49:1192 (October 1956).

Records of 260 adolescents disclosed an incidence for acne of 50 per cent. Eighty-six were mild and 28 severe. Four were very severe with cysts and scarring. "Habitual manipulations are described in dermatologic reports under the title of neurotic excoriations," Gaul explained. He believes this designation is unjust, however, "because manipulators usually are not neurotic. They are glad to learn that they have been injuring their skin. Most of them want to break the habit."

Those patients in whom good results were obtained were asked what they did to help achieve it. The reply was prompt. "I quit picking and squeezing," Gaul quoted. In most patients who have acne, the excoriation and preoccupation with skin ceases as the skin improves. In the 96 cases discussed, the manipulations were in direct relation to the duration of the acne.

Castor Oil Condemned

Although castor oil has been popular for the induction of labor for over a century, a study at Parkland Memorial Hospital, Dallas, showed that castor oil did not influence labor and was irritating to patients. Dr. G. C. Nabors quoted a professor who replied to a questionnaire concerning castor oil, as follows: "A dehydrating, debilitating, drastic drug; it should be used on machinery only."—*American Journal of Obstetrics and Gynecology*, January, 1958.

Samuel A. Sandler, M.D.

Hackensack

Iproniazid: An Effective Treatment for Depressions

The tranquilizers are all very well but sometimes the patient needs a stimulant rather than a sedative. If Dr. Sandler's experience is confirmed by others, we would appear to have in iproniazid a truly effective mood stimulant.

After treating depressions for over a quarter of a century, I have found iproniazid* to be the first satisfactory chemical agent for this condition. Following a suggestion made by Dr. Nathan S. Kline[1] and his associates, who did considerable research with this drug, I decided to try it on my private office patients. By now, I have treated 35 patients and results are encouraging. Iproniazid* was first used for tuberculosis at the Sea View Hospital in 1951. Eighty patients were then treated with dramatic results. Let me quote from Selikoff, Robitzek and Ornstein:[2] "The response was beyond anything we have ever seen with any other chemotherapeutic or antibiotic agents previously used by us. No bed cases remain. The wards have a completely new appearance. The cases were toxic, sorely sick and far advanced caseous-pneumonic cases."

As a result of the large doses used, these patients became toxic. Some became psychotic, others developed convulsions or severe constipation. Nearly all the patients developed ataxia, some insomnia, some showed twitching of the extremities, urinary spasm, generalized hyperreflexia and other complications. In addition, many showed evidence of cardiovascular and cerebral vascular insufficiency. Because of the widespread toxicity and disillusionment due to the large doses, iproniazid quickly fell into disrepute and disuse.

Instead of the 4 to 10 milligrams per kilogram which previous investigators had used, I have cut down the dosage to from 1 to 3 milligrams per kilogram. Most of the patients complained of ataxia and vertigo which would last from one-half minute to three minutes, and constipation. Some complained of "neuritis," twitching of the extremities, and insomnia. However, I have had no serious reactions. In practically every case the complication has been controlled because of the close and constant supervision of these patients, which was *always accompanied by psychotherapy*. The complications were transient, and results have been most gratifying. I have experimented upon myself with iproniazid for 3 months, and aside from some minor complications such as momentary vertigo and ataxia and severe constipation, have found the drug helpful as a tranquilizer and as a vitalizing agent. My capacity for work has been greater. Unlike my patients, I did not gain weight. In fact, I lost 6 pounds. My general well being has improved, my productiveness has increased.

*Marsilid®, Hoffmann-LaRoche, Inc.

Chemistry

Iproniazid* is a powerful inhibitor of the enzyme monoamino-oxidase. Monoamino-oxidase is one of the enzyme systems involved in the metabolism of epinephrine. Zeller and Barsky [3] showed that iproniazid* inhibited amino-oxidase and that this drug may be important in the study of the adrenergic system, in that it potentiates the effects of the adrenergic substances in the body. Iproniazid* acts as a cerebral inhibitor by preserving epinephrine and non-epinephrine because both hormones block synaptic transmission in certain parts of the central nervous system.[4]

Serotonin is also blocked by amino-oxidase and can be potentiated by iproniazid.* Central inhibition would explain the fall in blood pressure with iproniazid.* Serotonin is another powerful cerebral synaptic inhibitor [5] and is 20 times stronger than epinephrine. Serotonin is necessary for the maintenance of normal mental processes, and serotonin deficiency may result in mental illness. Excessive serotonin may also cause mental disease. The highest concentrations of serotonin [6] are concentrated in the area associated with the autonomic system.

Iproniazid* protects the functioning of serotonin against amino-oxidase, which would destroy it. This is so highly important because serotonin plays an integral role in the function of the nervous system. Serotonin is present in the brain [7] in the bound form and in that way it is protected from the highly active enzyme monoamino-oxidase. If too much iproniazid* is given, it prolongs the action of serotonin, interfering with its metabolism and therefore produces a toxic effect. One of the interesting research findings is that serotonin is 3 times greater in the brain stem than in any other area.[8]

PHARMACOLOGY

IPRONIAZID* is both a stimulant and a tranquilizer. From a practical standpoint, I feel that the chemistry of the interaction of the amino-oxidase enzyme system and iproniazid* revolves somehow around the reticular activating system in the brain stem. This serves as an integrating organ throughout the brain by its network of fibers, which goes to or is connected with all the important brain areas, especially the hypothalamus, the thalamus and the rhinencephalon. It awakens and stimulates the activity of the brain, but it also inhibits and restricts certain functions. Just as in the muscles we have agonist and antagonist, so in the brain we have inhibitors and release mechanisms.

A depression may be crudely compared with an automobile in a certain situation. Let us say that we have an efficient car which is not running because the brakes are on. Unless the brakes are released, the car will not do its job. The car is using gasoline and oxygen and the motor is turning, but if the brakes are on, the car is in the same situation as a patient who has a depression. Nothing is happening. The vital activities are reduced, and the patient feels useless, incompetent and unhappy. Iproniazid* seems to release certain vital capacities which had become inactive. It increases the appetite, the zest for living and the ability to shoulder the strains and stress of modern life. From what I have observed, the ego not only seems to be stimulated with a resulting greater drive, but somehow reacts with detachment to its daily irritations and annoyances.

CASE ONE

A 36-year old housewife was in a deep depression for 6 months. She was 7 months pregnant. She had frequent crying spells; had a compulsion to destroy herself by jumping out of a window. She described her mood as one in which she felt as if a big rock were attached to her neck, which dragged her down whenever she tried to do anything.

She was started on Marsilid® 50 milligrams three times a day. After being on this for a little over 2 weeks, she reported that she felt like her old self; "happy go lucky."

CASE TWO

A 59-year old housewife said that for the past 6 months she had been suffering from insomnia. She appeared hostile, confused, depressed and severely agitated. For the past 18 years, she had been treated by 5 different psychiatrists and had been in several mental institutions. She had received over 100 electroconvulsive treatments in 18 years. *Diagnosis*: Manic depressive psychosis.

She was placed on Marsilid® on June 28, 1957. On July 9 there was a remarkable change in her appearance for the better. On July 16, 1957, she reported she went to Saratoga for 4 days and she and her husband had a "second honeymoon," and enjoyed every minute of it.

CASE THREE

A 51-year old homemaker had previously been a successful businesswoman. In March 1956 she had a cerebral hemorrhage with a resulting right hemiplegia. She stated, "I stopped living after that." She cried from morning till night. She felt she was a burden to her newly married husband. She wanted to die. On March 1, 1957 she was placed on Marsilid®. On April 26 she appeared radiant, and for the first time she said she felt, "very, very good," and from then on has been taking care of her home. In addition, she enjoys reading and watching television. She sleeps well and "socializes" freely. She is very pleased with her progress and so is her husband.

CASE FOUR

This 45-year old man was first seen on October 20, 1956. He is a government employee. He said he had spells of depression for the past 30 years. These included 12 "breakdowns" in the past 15 years. He had 2 series of shock treatments previous to coming to my office. *Impression*: Manic depressive psychosis.

On May 3, 1957 he was started on Marsilid®. On June 20, 1957 he reported he never felt so well and was grateful for everything that had been done for him.

CASE FIVE

A 54-year old housewife was first seen on June 5, 1956. She had been taking care of her 82-year old mother who was ill with carcinoma. The fatigue of being up day and night exhausted her. She had trouble thinking and concentrating. She acted as if some great impending danger were about to overwhelm her. Then the patient's mother died. Following this she felt guilty about "neglecting my sick mother." *Impression*: Reactive depression.

The patient was given Marsilid® on March 6, 1957. By May 20 she had gained 20 pounds. She stated that she "felt wonderful," that everything was under control and she was doing things better than she had done in years.

CASE SIX

An industrial engineer 34 years old, was first seen on June 11, 1956. He suffered from anorexia, loss of weight and insomnia. He complained that he could not now do the work which he had been doing successfully for the past 10 years. He had a feeling of loneliness and inadequacy. He had always been a shy, seclusive personality. He complained, "I'm at the end of my rope." *Diagnosis*: Reactive depression in a schizoid personality.

He was placed on Marsilid® on June 11, 1957. Seen on July 1, 1957 he stated that he drove to Buffalo and back for a weekend holiday, a distance of 700 miles just to make his parents happy. He enjoyed the experience. Since then he had had some dates and found them very pleasant.

CASE SEVEN

A 43-year old housewife was first seen on October 23, 1956. She complained of anorexia and insomnia. She was afraid of going insane. She was disturbed because she could not do her housework and felt that she would land in a mental institution just as her sister did the previous year. On March 6, 1957, she was put on Marsilid®. When seen on July 19, 1957, she had gained 10 pounds, was relaxed and smiling. She said that she was doing all her housework, even the heavy laundry. She was sleeping very well, "socializing" easily and felt that she had made great progress.

CASE EIGHT

A housewife, 65 years of age, was seen on March 6, 1956. She complained of crying spells, gastrointestinal disturbance and anorexia. She was certain she had a malignant disease. She had ideas of self-destruction such as jumping off her roof. *Diagnosis*: Involution melancholia.

On March 2, 1957, patient was started on Marsilid®. On April 3 she looked well and had gained eight pounds. On July 24 she reported that she was taking care of her home, doing all her cleaning, climbing ladders, shopping out of town by herself and felt self-confident.

CASE NINE

A school teacher 39 years of age, complained that she was being persecuted, that her husband was trying to institutionalize her. She had been doing a great deal of crying and had frequent spells of depression. She recently returned from a vacation highly agitated, with no apparent cause. She said she wanted to die and feared that she might destroy herself. *Diagnosis*: Hypomania in a manic depressive psychosis.

On April 30 she was put on Marsilid®. On June 12, 1957 she reported she had a "wonderful" weekend in the country. She is at present taking care of all her responsibilities in school and in the home.

COMMENT

THE careful and skillful use of iproniazid* should bring about a great advancement in the treatment of mental illness. This drug surpasses any other agent that is known to me in the treatment of depressions. It seems to clear up all types of depressions. Administration of the drug should always be associated with competent psychotherapy. Marsilid® will release latent and vital forces in the patient which have been repressed for years.

The necessity for close scrutiny and careful observation of the patient's progress is reflected in a case now under my care. Under a regime of iproniazid,* her depression lifted but was followed by a psychosis with features of confusion and delusions. Iproniazid* may release repressed latent psychoses. Unless the doctor is aware of this possibility, harm may be done. Fortunately, because of the frequent opportunities I have of seeing this patient, I was able to handle this complication, and the

patient is now slowly making progress in recovering from her psychosis.

A number of patients have reported: "I haven't felt as well in years." Some have even said, "I've never felt better in my life." One patient stated, "It is appalling and overwhelming what these pills can do to change the whole course of your life."

While electroconvulsive therapy marked a great advance in the treatment of depressions, it was an empirical practice, somewhat strenuous in its administration, highly useful to a large number of people, who benefited by this treatment. However, in its path were left numbers of fractures, loss of memory, confusion and in rare cases, mental deterioration. This treatment, worthwhile and desirable as it was and is, created fear and anxiety not only in the patients themselves, but in their families. This fear and anxiety were not entirely unwarranted. Because of the memory impairment with resulting confusion, psychotherapy was not as effective as it would otherwise have been in a patient whose memory and orientation were more adequate and better adjusted to reality. Iproniazid* disposes of the shortcomings and dangers of electroconvulsive therapy and facilitates the accompanying psychotherapy.

SUMMARY

1. This paper reports a series of 35 cases of varied depressions which I have treated with iproniazid* and am still in the process of treating with excellent results. In 4 cases, doubtful or negative results occurred.

2. After 6 months of investigation and treatment, during which I used myself as a guinea pig, taking iproniazid* for about 3 months, there has been no apparent permanent or serious reaction.

3. Iproniazid* seems to be the most desirable and effective treatment for depressions. But in careless or unskilled hands, it may be highly toxic and produce considerable damage. It should not be used by any physician unless he can sit down for at least half an hour with the patient and administer psychotherapy.

254 Union Street

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ANTHONY R. COMUNALE, M.D.

Rahway

Two Cases of Thrombocytopenic Purpura*

The dramatic manifestations of thrombocytopenic purpura seem less common today than they used to be and the disease may be forgotten. Dr. Comunale here presents two cases, one involving a successfully treated erythroblastosis and the other an acute purpura in a middle-aged woman.

THE spontaneous bleeding of idiopathic thrombocytopenic purpura, once seen, will never be forgotten. While it occurs in young girls, female adults apparently suffer more severely. It is accompanied by a profound anemia. The patient has the appearance of a person with acute blood loss. Red blood cells are markedly reduced in number. Hemoglobin is very low. White blood cells and the platelets are greatly diminished.

The spontaneous bleeding is usually preceded by purpuric spots in the skin and petechial hemorrhages in the muscles. As the condition progresses, severe bleeding is observed from the mucous membranes of the nose, throat, gastro-intestinal tract, genito-urinary and other systems. Death results from the acute blood loss and from hemorrhage into the brain.

Soon after birth the purpuric infant becomes listless; looks very pale; refuses to take its formula and then develops a deep jaundice.

Thrombocytopenic purpura is the result of either a vascular defect; inadequate or poorly functioning blood platelets; or faulty coagulation.

The vital function of circulating red blood cells, is to hold in non-diffusible form the hemoglobin, which is essential for the transportation of oxygen. The blood stream is a medium for the transportation of the white blood cells to an infected area, where they serve as phagocytes against the infection.

Platelets are associated with the vascular endothelium for the maintenance of its integrity. The enzyme systems in the plasma provide a second line of defense for the blood vessels, converting soluble fibrinogen to fibrin at the site of injury.

In a review of the literature, I noted that spontaneous bleeding occurred after the administration of steroids in arthritic diseases. Complications have also been reported following the use of anticoagulant drugs, such as the coumarins in coronary artery disease. Some people have excess anticoagulants which prolong the clotting time of normal blood. After repeated transfusions of whole blood and plasma fractions which contain the anti-hemophilic globulin, there is produced in the plasma, antibodies demonstrable by the precipitin test. These antibodies combine with and neutralize the anti-hemophilic globulin and produce a refractory state of incoagulability of the blood.

DIAGNOSIS

THE diagnosis of thrombocytopenic purpura is based on the history (which should include reports of previous medication, such as steroids or anticoagulants); a physical examination and a correlation of the laboratory findings. I include a spinal tap to evaluate the kind of fluid and pressure; and if necessary x-rays or endoscopy if needed for differential diagnosis. The more important laboratory tests

*Read by invitation July 9, 1957, to the staff of the Rahway Memorial Hospital. Acknowledgment is made of the valuable assistance of Doctors Edward Levitsky, Leslie Townsend and Frederick M. Offenkrantz.

include: (a) A determination of the hemoglobin level; (b) A microscopic examination of the blood, with supervital staining of the red blood cells; and (c) Biopsy of the blood-forming tissues. Quantitative methods may be needed to determine average volume; hemoglobin concentration, and fecal urobilinogen.

The diagnosis of thrombocytopenic purpura requires differentiation from the acute blood loss occurring in other diseases. Thus massive upper gastro-intestinal hemorrhage may result from: (a) Ruptured peptic ulcer; (b) Esophageal varices; (c) Tumors of the stomach; (d) Intestinal polyposis; (e) Cirrhosis of the liver; (f) Gastric ulcerations and angiomas.

In nontraumatic intracerebral hematoma, bleeding is secondary to: (a) Hypertensive or atheromatous vascular changes; (b) Brain tumor; (c) Ruptured basilar aneurism.

Bleeding may be secondary to polycythemia or other blood dyscrasias.

Illustrative of a case of acute blood loss is that of a middle aged man with ruptured esophageal varices. Spontaneous expectoration of bloody mucus appeared. The bleeding seemed to stop temporarily, then recur more severely. Whole blood was transfused. Attempt to determine the site of the bleeding by x-ray was unsuccessful because the patient died. He was a bartender and autopsy revealed cirrhosis of the liver.

In another case the origin of the hemorrhage into the central nervous system was discovered only at autopsy, where a ruptured basilar aneurism was found. She had complained of periodic occipital headaches. Treatment with analgesics and estrogens was ineffective. The history, physical examination, x-rays and laboratory studies were negative. She lapsed into coma. There was no hemiplegia. Xanthochromic fluid with increased pressure was obtained on the spinal tap.

Petechiae and multiple capillary thrombi appeared in the lower extremities in a middle aged patient with atheromatous vascular changes. He had had several episodes of angina pectoris, and an acute upper respiratory infection. An allergenic reaction developed immediately after the administration of penicillin in beeswax. The shock was severe. One cubic centimeter of epinephrine was given intramuscularly. Petechiae appeared in both lower extremities, but none in the upper extremities. The areas over the petechiae were acutely tender and painful to the touch. Edema was not apparent as the patient was in bed.

He had been a toolmaker but bee-keeping was his hobby. Whether the allergy was a result of possible bee protein in a minute amount in the beeswax may be questioned. Schofield,[1] states that severe symptoms and the unusual degree of sensitivity, following bee stings, are due to the bee protein. Bee venom causes only a slight reaction when the protein is removed. Some people develop reactions and asthma by inhaling air or handling dusty bee equipment.

CASE ONE

A 47-year old woman had the signs and symptoms of a fulminating idiopathic thrombocytopenic purpura. Within a few days, she was dead with extensive hemorrhage generally and into the brain. She had had an upper respiratory infection a year ago, with a septic temperature. Treatment consisted of antibiotics and antipyretics. While she had been a heavy smoker, she did not drink.

There was no history of liver disease, jaundice, ascites, or surgery for peptic ulcer. There was no complaint of dysphagia, regurgitation, radiating and burning pains in the chest, but she had had a few nose bleeds. The family history for prolonged bleeding was negative and there were no indications of hereditary hemorrhagic teleangiectases. There was no satisfactory evidence of her having taken anticoagulants, salicylates, steroids, phenylbutazone, reserpine, oxytocics, or phenothiazine compounds. However, emotional factors, improper diet and poor relaxation had produced a state of malnutrition and secondary anemia. These factors aggravated a menopausal syndrome, with its symptoms of estrogen deficiency already present.

She entered the hospital with pallor, weakness and shortness of breath. The following were administered: whole blood, penicillin, glucose, saline, streptomycin and promazine (in the form of Sparine®). The next day she was bleeding from the nose, mouth and genito-urinary tract. She became delirious and incontinent. Ecchymotic spots appeared at numerous places. Pulse became fast and weak. Blood pressure rapidly fell. We administered 0.1 milligrams of crystalline digitoxin. Then we added vitamin K and later administered the sodium succinate ester of hydrocortisone (Solu-Cortef®). Nothing helped. The bleeding became worse, the spinal fluid became more and more yellow, its pressure ascended. Meticortelone® had no

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influence on the bleeding, and within two days she was dead.

Here is a summary of the autopsy report: throughout the skin, ecchymotic areas of various sizes were found. The heart was moderately enlarged, with petechial hemorrhages over the pericardium. The myocardium was flabby, brownish and suggestive of myomalacia; the chambers were dilated with petechiae in the epicardium. The abdomen contained 200 cubic centimeters of bloody fluid.

The liver was gray with a moderate amount of fatty content. No disease was found in the biliary tract. In the intestine, there was much serosal hemorrhage, but no toxic material was evident.

The kidneys were enlarged with numerous hemorrhagic areas on gross section. The pelvic viscera presented the same findings.

The spleen was enlarged secondary to the thrombocytopenic purpura.

The generalized hemorrhagic diathesis was evident in the central nervous system, viscera and skin.

CASE TWO

PURPURA hemorrhagica in the newborn is called erythroblastosis fetalis. Babies die if this is not recognized and treated immediately. Cerebral palsy is associated wth erythroblastosis.

Rh positive fetal cells enter the maternal circulation through a break in the placental capillary system. An antigen-antibody response is initiated, with the production of Rh antibodies. The placental barrier is crossed and Rh antibodies then attack and destroy the fetal red blood cells.

A 22-year old woman who had been married for two years, complained that she was unable to become pregnant. Menses were regular, lasted 3 to 5 days but were scanty. Blood pressure had been persistently low. Weight was normal. There was no gynecologic abnormality. The blood factor was Rh negative with type B blood and the husband was with Rh positive and type A blood.

Treatment included liver extract; vitamin B_{12}; thyroid; vitamin D; iron; and dibasic calcium phosphate. She became pregnant and a normal female child was born. Eighteen months later, she again became pregnant. Blood pressure was 110/60. Weight increased from 139 to 160 pounds at term. The urine with exception of "a little albumin" was essentially negative. Leg cramps and varicosities of both thighs were the only complaints.

The previous prenatal care was omitted as the patient was active and the general condition appeared satisfactory.

A female child was delivered normally and uneventfully. Within a few days the baby developed signs of listlessness, a feeble cry and appeared profoundly anemic. She refused the formula and rapidly became very jaundiced.

The laboratory tests of the baby's blood and the clinical findings indicated a hemorrhagic condition which had to be corrected immediately. An exchange transfusion was done by Dr. Edward Levitsky and me. The whole blood was given intravenously through the baby's umbilical vein. We used a pint of whole blood to which was added calcium chloride solution, crystallin penicillin and the antihistamine, chlorprophenpyridamine. Throughout the operative and postoperative course the baby acted well. She was then placed on the regular formula within a few days with added vitamins and iron preparations to prevent secondary anemia. The weight remained above normal and no further trouble ensued.

In future pregnancies, there is danger of erythroblastosis fetalis, because the mother already has been sensitized to platelet antigen in this pregnancy. This could even happen in normal mothers who may have been sensitized to platelet antigen in a previous transfusion, or to mothers who are unaware of a lowered platelet count. It may also occur in women who have had a splenectomy or following drug induction by the ingestion of quinine.

The prognosis is good if the normal number of platelets is restored within the first few weeks; and poor if the pregnancy is already associated with purpura.

Treatment is directed to the specific factor involved. Replacement therapy is provided in the case of nutritional deficiencies with the following: (a) vitamin B_{12}; (b) folic acid or iron; (c) liver and stomach preparations; (d) ascorbic acid. Splenectomy removes the hemolytic organ which produces the fragility of the red blood cells and thrombocytopenic purpura. Chemotherapy, such as quinine for the hemolytic anemia of malaria; and antibiotics for the sepsis.

Transfusion of whole blood is passive, except in erythroblastosis fetalis. The abnormal plasma antibodies are removed and the Rh negative red blood cells are supplied; in which case there is no stimulation or depression of the blood forming organs.

Transfusion of whole blood increases the blood volume, which is lost in the severe hemorrhage; increases the hemoglobin, which becomes critically low in value from the anemia;

and adds more platelets temporarily to the blood stream. The normal plasma globulins reduce the clotting time in hemophilia. Transfusion also alleviates fear.

SUMMARY

AN ACUTE thrombocytopenic purpura occurred in a middle aged patient who was previously suffering from menopause. Emotional factors, malnutrition from improper diet, poor relaxation and secondary anemia aggravated the menopausal syndrome with its symptoms of estrogen deficiency. Despite whole blood transfusions, the blood loss was greater than the blood intake. Petechiae and areas of ecchymosis were marked with large areas over the various parts of the body. Bleeding occurred from the mucous membranes of the nose, mouth, gastro-intestinal tract, genito-urinary tract and into the central nervous system. Pancytopenia was marked.

A case of erythroblastosis fetalis was recognized promptly and successfully treated with whole blood in an "exchange transfusion."

ADDENDUM

Subsequent to the submission of this paper, Dr. Comunale submitted the following:

An exchange transfusion was not necessary for the male living child, born of a mother in which a case of thrombocytopenic purpura has been reported.

Starting one month after the last menstrual period, the mother received 200 milligrams of ascorbic acid daily, orally. Her diet included an increase in the normal amount of citrus fruit and their juices.

During the sixth month, the ascorbic acid was increased to 250 milligrams, once daily. From the seventh month to term, vitamin B complex was added.

It is well to remember that excessive doses of ascorbic acid may produce a temporary diarrhea.

A patient who had developed a non-thrombocytopenic purpura from a drug for sedation, was given 500 to 750 milligrams of ascorbic acid, in divided doses. The diarrhea was profuse with abdominal discomfort.

1709 Irving Street

Teeth Can Be Transplanted

Writing in the January 1958 *Journal of the American Dental Association* (57:77) Doctors C. C. Fong and R. G. Agnew say that it is possible to transplant a tooth from one part of a patient's mouth to another successfully in certain cases.

The investigators describe a technic for transplanting the third molar or "wisdom tooth" in an early stage of root development to the site of a missing permanent first molar.

Loss of a first permanent molar often is responsible for crowded teeth, chewing difficulties, diseases of the gums and painful jaw joints.

They described the case of a 16-year old girl in whom a developing lower wisdom tooth was transplanted to the empty socket left by removal of an abscessed first molar.

At the end of eight months the socket was well filled with developing new bone and the tooth was firm; at the end of five years the transferred tooth was full size and the roots had lengthened. Response of the tooth to heat and cold was similar to that of other teeth.

Carl A. Gherardi, M.D.

Newark

Subphrenic Abscesses*

The development of antibiotics has made surgeons less conscious of subphrenic abscess. As Dr. Gherardi points out, however, this is a serious complication. For reasons here spelled out, the extraperitoneal approach is advised as the best of the three drainage routes to the subphrenic space.

The subphrenic space is the area limited above by the diaphragm and below by the transverse colon with its mesentery. The space includes both intraperitoneal and extraperitoneal areas. Abscesses in the subphrenic space may be anatomically classed as intraperitoneal or extraperitoneal. Abscesses in the intraperitoneal area are further classed as subhepatic and suprahepatic. The abscesses are also classed as right or left, anterior or posterior. Posterior extraperitoneal abscesses are also perinephric abscesses.

ETIOLOGY

Usually the cause of a subphrenic abscess is a suppurative process in the abdomen, although primary hematogenous subphrenic abscesses have been described. There are five different pathogenetic routes:

(1) *Extension by continuity and contiguity.* The commonest example is diffuse peritonitis. Here the exudate has the tendency to deposit in two natural pouches (posteriorly situated) upwards and downwards to the anterior convexity of the lumbar spine. From the upper one a subphrenic abscess may result. Other instances are the inflammatory processes of the kidney causing paranephric and perinephric spread. An abscess of the liver, as well as a thoracic empyema allowing contamination of the subphrenic spaces, are further examples of extension by contiguity.

(2) *Distant extension.* An acute inflammatory process of the appendix or cecum are examples. The development of a subphrenic suppuration is conditioned by the anatomic relationship between these two areas by means of lymphatic channels. The lymphatics of the entire abdominal cavity concentrate below the diaphragm. Through this lymphatic stream such a distant extension may be found.

(3) *Retrograde lymphatic infection* develops from thoracic empyema, pneumonia, or abscess of the lung. The thoracic lymphatics between the area above the diaphragm and the subphrenic space become infected and secondarily blocked. The resulting stasis leads to rupture of the channels with spillage of infected material.

(4) *Metastatic infection.* The possibility of infection of the subphrenium carried by the blood stream has been repeatedly reported. In such cases, the original lesion is usually an osteomyelitis, furunculosis or septicemia. In these cases the subphrenic abscess is a consequence of peripheral liver suppuration spreading by micotic embolism.

(5) *Direct implantation.* The subphrenic area becomes infected by injury which may be a penetrating wound of the lower thorax or upper part of the abdomen. Here the infection is due to micro-organisms carried in by the traumatizing instrument or to micro-

*This work is from Dr. Crecca's surgical service at the Martland Medical Center in Newark. Dr. Gherardi is a resident surgeon at that hospital.

organisms from traumatic perforation of abdominal organs.

We had 13 cases of subphrenic abscesses at Martland Medical Center during the last 10 years. Four were associated with gastro-intestinal perforation and three additional cases developed after gastrectomy. There were also two post-cholecystectomy abscesses and one each associated with appendicitis and septic abortion. In two, the cause was undetermined. Of the 13 cases, the one following appendicitis was a perinephric abscess, and the other 12 were subhepatic or suprahepatic.

Thus, in our series, highest incidence is represented by perforative diseases of the duodenum, followed by post-gastrectomy and post-cholecystectomy cases. Acute inflammatory process of the appendix, as an etiologic factor, accounted for only 7.6 per cent, in contrast to earlier reports, in which the incidence is given as 25 to 30 per cent. This drop in frequency is the result of improved and earlier diagnoses in appendicitis, as well as the result of antibiotic therapy. Almost unchanged is the frequency of the subphrenic abscesses after surgery of the stomach and duodenum and particularly of the biliary tract. The right suprahepatic spaces were involved more often than the subhepatic ones. The abscesses following surgery or disease of the biliary system, were usually found in the right suprahepatic spaces as reported in other statistics.[1]

SYMPTOMS

Onset of subphrenic abscess will almost always be insidious regardless of its close connection with any surgical procedure. There are five sets of subjective and objective symptoms.

(1) *General symptoms.* Usually the patient appears pale, dyspneic, emaciated, anxious, apprehensive, with oblique respiration. He complains of vague malaise, fatigue, loss of appetite and some dull ache in the region of the abscess. With further evolution of the process, the temperature and pulse become elevated. The temperature becomes spiking in character and is accompanied by cold chills and profuse perspiration. As soon as the serosal peritoneal involvement reaches greater intensity, nausea and vomiting appear, as well as hiccups, belching and pain in the region of the corresponding shoulder. Severe anemia and jaundice may develop with evidence of severe intoxication. Leucocytosis and neutrophilia are usually observed.

(2) *Thoracic symptoms.* The side of the chest involved in the process will show decreased respiratory movements. At times respiratory excursion on the affected side may be totally absent. The intercostal spaces may be found widened or retracted, the latter being present in the deeply placed abscesses. Tenderness may be elicited upon pressure on the costal arch, with tenderness along the tenth rib anteriorly or along the twelfth rib posteriorly, if we are dealing with suppuration in the anterior subhepatic or posterior suprahepatic areas respectively. Impaired lower thoracic percussion may be present. The cardiac area of percussion is displaced upwards in left sided subphrenic abscesses. In the area of impaired percussion, the breath sounds are diminished or suppressed, and transmitted bronchial breath sounds may be heard. A friction rub has been described in the lower part of the thorax, as an expression of the rubbing of the diaphragm against the inflamed upper surface of the liver.

(3) *Abdominal symptoms.* The patient usually prefers a particular posture in bed, trying to avoid pressure on the region involved because of the resulting local tenderness. The same part of the abdominal wall will not show motility during the respiratory excursion: the area reacts with a "functional defensive paralysis." If the abscess cavity has a peripheral development, it will show as a bulging mass. There is also a corresponding edema of the skin associated with bluish-reddish coloration. If the cellulitis surrounding the abscess is circumscribed and the process is peripherally situated, a mass can sometimes be felt on palpation. There is a muscular guarding or rigidity

1. Faxon, H.: New England Journal of Medicine, 222:289 (1940); *also* Ochsner, A. and DeBakey, M.: International Abstracts of Surgery, 66:426 (1938); *also* Hochberg, L. A.: Archives of Surgery, 36:131 (1938) *and* Rabin, G. B.: Journal of the New York Mt. Sinai Hospital, 17:717 (1951).

peculiarly characteristic: palpation will elicit a sense of fullness. The liver may be found downwardly displaced when the abscess is suprahepatic. By percussion, the location and the limits of the abscess may be outlined.

(4) *Lumbar symptoms.* When the abscess involves the lumbar region, a reflex spasm of the quadratus lumborum muscle will be noted. This may lead to scoliosis on the affected side. The area may show edema, bulging, increased temperature, and tenderness, with dullness and occasionally hyperresonance depending on the presence or absence of gas.

(5) *Radiologic findings.* The roentgen examination is the most helpful test in the diagnosis of subphrenic abscess. A series of well-taken films together with fluoroscopy will almost invariably reveal the data for an exact diagnosis. The roentgenograms must be taken in various views with the patient in erect and prone positions, and during inspiration and expiration. There are some cases in which a fluid-air level is found, and in which the diagnosis becomes obvious. There is one sign which should be considered pathognomonic: a motionless, elevated diaphragm. This sign is the one which occurs most frequently, and is present in the early stage of development of any subphrenic abscess.

In certain subphrenic abscesses only a supraelevated diaphragm with a dense diffuse shadow underneath it without gas bubble is seen. In these instances, the possibility of pleural effusion cannot be ruled out by routine x-rays. In such cases, the pneumoperitoneal technic suggested by Lilienthal [2] outlines the area between the liver and the diaphragm, thus revealing the abscess.

COMPLICATIONS

BECAUSE of the critical area of subphrenic abscess, between two large cavities of the human body, extension of the inflammatory process in either direction is a serious involvement.

Abdominal complications. The abscess cavity may rupture into the free peritoneal cavity producing peritonitis, or rupture into a hollow viscus or through the skin by progressive extension.

Thoracic complications are the result of the spread of the initial process by different mechanisms. In most cases, the lymphatic route is responsible for certain complications as in pleural effusion, pneumonia, pneumonitis, lung abscess, pericarditis, or mediastinal abscess. In the latter the cause is a breakdown of a mediastinal satellite lymph gland. Spread may be by direct progressive extension or by micotic embolism.

Thoracic empyema may be similarly produced or it may be due to a rupture of the subphrenic abscess directly through the pleural space, by perforation of the diaphragm.

Bronchopleural fistula is an indirect complication of subphrenic abscess. It is the final outcome of other infectious processes secondary to the subphrenic suppuration. In other words the fistula is the result of complications such as empyema, pneumonia or lung abscess.[3]

PROGNOSIS

SINCE the introduction of antibiotic therapy the prognosis and mortality of subphrenic abscess have improved. In spite of this, however, subphrenic suppuration is a serious disease likely to lead to several complications which may threaten the patient's life. Early treatment and proper management reduce morbidity. Generally speaking, cases of subphrenic abscess without abdominal and particularly thoracic complications are the most benign. In endothoracic complications the mortality rate is about 35 per cent. Of paramount importance is the type of surgical treatment. The general surgical rule of an adequate drainage applies to these cases. Transperitoneal drainage gives the worst prognosis, while extraperitoneal drainage, posterior or anterior, leads to the most satisfactory results.

PREVENTION

MANY subphrenic abscesses subside without requiring surgery. Prophylactic measures must be observed in the operating room: (1)

2. As reported by Cameron, D. and Sykes, E.: American Journal of Surgery, 83:412 (1952).

3. Berens, J. *et al.*: Surgery, Gynecology and Obstetrics, 34:463 (1953). Also *see*: Clagett, O. and Tinney, W.: American Journal of Surgery, 66:189 (1944).

avoiding contamination, (2) preventing spillage of secretion and (3) maintaining complete hemostasis. Even a small hematoma may be the source of a suppurative process. An acute surgical inflammatory disease with exudate should be drained with dependent technic. A patient with generalized peritonitis or a ruptured viscus should be placed in the Fowler position, to allow drainage toward the pelvis rather than to the subphrenic area. Conservative care is indicated. By this is meant antibiotic therapy, dependent position, local application of dry heat, immobilization of the involved thoracic side and general supportive therapy. This should be followed together with careful and constant checking of the patient by examination or, if necessary, by x-ray.

The earliest signs of failure of such treatment are: suppurative type temperature, chills, signs of intoxication, increased pain, swelling and particularly the first visualization by x-ray of a hydro-aereous level signals for institution of surgical treatment.[4]

SURGICAL APPROACH

As soon as the diagnosis of a subphrenic abscess is made and indications for treatment are established, any of three different approaches may be used: the transperitoneal, the transpleural and the extraperitoneal.

The *transperitoneal* jeopardizes the peritoneal cavity since there is danger of diffuse septic contamination. A transperitoneal procedure, therefore, should be considered only in cases of localization of the abscess in *both* left inferior spaces. In such cases, fortunately, secondary adhesions are present between the walls of the abscess and the parietal peritoneum, thus preventing any endoperitoneal spread of the infection.

The *transpleural* route presents, in turn, the same general disadvantage of the transperitoneal approach. It leads to possible contamination of the pleural cavity with consequent empyema. However, in this instance when the pleura has been reached (usually through an incision carried out at the level of the ninth, tenth or eleventh rib with resection), inflammatory adhesions, with secondary obliteration of the pleural cavity corresponding to the exposed angle, may permit the safe entrance of the abscess cavity through pleura and diaphragm. If this fortunate situation is not present, the transpleural operation should be carried out as a two stage procedure with the same general technic which was used in the early treatment of lung abscess.

The *extraperitoneal* approach is the best procedure for a subphrenic abscess if either the posterior or the anterior spaces are involved. Important advantages of this technic are the lower risk of contamination of uninvolved serous cavities, the single stage procedure by which any further delay in draining the exudate is avoided, and the resultant dependent drainage. The extraperitoneal route, then, can be used in draining a posterior abscess as well as one located anteriorly. When the posterior approach is indicated, the length and position of the twelfth rib must be established and carefully defined, because the presence of an overlooked rudimentary twelfth rib might distort the orientation and lead to a false surgical approach.

After subperiosteal removal of the twelfth rib, the dissection is carried out horizontally and laterally at the level of the first lumbar vertebra to avoid a possible injury and perforation of the pleural sinus. The inner half of the twelfth rib should be avoided as the pleura extends to this level medially (toward the spine).

In the anterior approach, incision is carried out parallel to, and immediately below the anterior costal margin. The external surface of the peritoneum is reached and its dissection from the undersurface of the diaphragm is accomplished until the abscess wall is reached.[5]

4. Adams, H. D.: Surgical Clinics of North America, 28:685 (1948); *also* Faxon, H.: American Journal of Surgery, 10:114 (1941).

5. Hochberg, L. A.: Annals of Internal Medicine, 17:182 (1942); *also*: Rabin, G. B.: Journal of the New York Mt. Sinai Hospital, 17:717 (1951).

I wish to thank Dr. W. D. Crecca, Chief of the "A" Surgical Staff and the late Dr. G. I. Cetrulo, for the teaching, suggestions and assistance received in the compilation of the present paper.

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Alexander Strelinger, M.D.

Elizabeth

Clinical Experience with Hibernation

When excessively speeded up life processes threaten to exhaust the organism, a forcible slowing down may prevent death. One method of doing this is to induce hibernation. Dr. Strelinger reports the use of this technic to prevent postoperative shock and to combat shock which had already developed.

Hibernation is widely used in France for the prevention and treatment of shock. Though hypothermia has been widely used in this country, hibernation is not popular. The two methods differ in their theoretical background as well as in the technic of application.

Rationale

The human being is a homeostatic animal. Such animals attempt to keep their interior milieu in physical equilibrium. They try to ward off the changes which may be induced by alterations in their surroundings. Reactions to this end are "homeostatic." By comparison, lower animals permit their interior milieu to vary according to changes in their surrounding and thereby lose their liberty from their environment. These are poikilothermic animals.

In homeostatic animals a shocking event affecting the body is answered by the alarm reaction of Selye, consisting ordinarily of shock and countershock. Through various phases, countershock tries to re-establish body homeostasis. They are sympathicomimetic reactions. For example, epinephrine is poured out and the peripheral vessels contract to raise the blood pressure thereby offering satisfactory blood volume to central organs.

In shock the sphincters of arterio-venous anastomoses and of capillaries are relaxed. These vessel structures and the metarterioles are engorged with blood. In reversible shock certain pharmacologic agents ordinarily used for raising blood pressure will be effective in closing the sphincters and in reducing the engorgement. In deep, so-called "irreversible" shock, these agents are not effective. Peripheral vascular collapse will ensue and will continue.

Laborit [1] the initiator of hibernation, groups the reactions connected with shock into a catabolic and an anabolic phase. The catabolic phase is actuated by epinephrine and glucocorticoids; the anabolic phase by histamine, acetylcholine and 17 ketosteroids.

When an aggressive incident initiates a chain of events, homeostasis is disturbed. When the aggression is of moderate intensity, the ensuing reactions will re-establish homeostasis. But when an excessive reaction produces deep shock, the reactions of countershock may fail. In these cases the reactions try to hold the body fast at the homeostatic level. They fail

1. Laborit, H. and Huguenard, P.: Hibernotherapie en Chirurgie at Medicine. Masson et Cie. Paris 1954.

to save life because they produce extreme exhaustion. At such times epinephrine and cortisone exhaust the organism instead of preserving it.

HIBERNATION

According to the theory of hibernation the life of a deeply shocked and normally homeostatic animal can be saved only by blocking the homeostatic reactions thereby preventing the onset of extreme exhaustion. Hibernation achieves this by a multiple neural block, a controlled inhibition of the neurovegetative system. By suspending homeostasis, hibernation reverts the organism to a poikilothermic pattern. Life processes slow down. Twilight condition and hypometabolism set in. Hypothermia is an associated feature; even without cooling it will occur as a result of hypometabolism.

Hibernation corrects vascular collapse by closing the sphincters and by eliminating the engorgement of the capillaries, of the arteriovenous anastomoses, and of the metarterioles. This mechanism is essential in treating shock by hibernation. In prevention of shock an additional advantageous feature is the reduction of the basal metabolic rate. Hypothermia by cooling also leads to a reduction of the basal metabolic rate, but it does not offer the stabilizing mechanism of the peripheral vascular circulation.

I used hibernation in two patients prior to surgery for prevention of shock; and in two cases for treatment of shock.

CASE ONE

The first surgical case was a 73 year old man. He had diabetes for a long time and neglected it. When I first saw him, he told me that he had intense and continuous pain in the right upper quadrant for one week preceding my examination. His family doctor prescribed chlortetracycline. The pain became more intense and he felt worse.

The essential finding was a two-fist sized mass in the right upper and partly in the right lower quadrant, painful, with muscle-guarding above it. He was hospitalized with the diagnosis of acute cholecystitis, pericholecystitis and neglected diabetes.

The relevant laboratory findings initially were: urine: albumen 3 plus; sugar 1 plus; acetone negative; 10 hyaline casts per high powered field. The electrocardiogram was within normal limits. Within 10 days after admission the blood sugar was brought to normal. The mass in the abdomen decreased somewhat, but continued to cause pain. He was scheduled for surgery but he was considered a poor risk. Prior to surgery he was "hibernated" using the Laborit schedule.[1] As hibernation progressed, the blood pressure was reduced from 120/80 to 94/52, the pulse rate from 80 to 60, the rectal temperature from 98.4 to 96.2, and the respiratory rate from 16 to 9. The patient was taken to the operating room, apparently asleep, but arousable to some extent. On command he opened his mouth. Then the anesthetist intubated him without additional anesthesia. During the operative procedure oxygen and nitrous oxide were administered, a minimal amount of thiamylal* and of muscle relaxant were added.

On operation the mass was found to consist of fibrin, pus and the gall-bladder. The latter was shaggy, friable and hemorrhagic. The operative procedure entailed a fair amount of blunt dissection; the cystic artery broke. Forceful retraction was necessary to visualize the artery stump. The condition of the patient remained very satisfactory throughout the procedure. The rectal temperature declined to 95.4.

On the afternoon of the day of the operation the color of the patient was pink and his peripheral veins were full. The postoperative recovery was very smooth and uneventful.

CASE TWO

The second surgical case was a 60-year old woman. Her general condition was good. She had an abdominal abscess resulting from slough of a segment of the descending colon following diverticulitis. An abdomino-cutaneous fistula was present; fecal matter entering the abscess cavity passed partly by the fistula and partly by the caudad part of the descending colon. There were diverticula along the whole colon. Excision of the abscess, colectomy and ileo-proctostomy were planned. She was "hibernated" prior to surgery.

Forty-five minutes before starting the operation, with hibernation partly induced, her blood pressure was 100/70, the rectal temperature 96.8, pulse rate 82, and respiratory rate 12. On arrival in the operating room she was in twilight condition: apparently deeply asleep, but she could be aroused. She was intubated without added anesthesia. She received nitrous oxide and oxygen throughout the procedure, which lasted 3½ hours, but only 25 cubic centimeters of 2 per cent thiamylal* solution were added. Muscle relaxant was not needed at all.

During the operation the freeing of the mass containing the abscess was very difficult, and involved considerable handling of tissues. For a

*We used the Parke-Davis brand of thiamylal, tradenamed as Surital®.

while it seemed that the procedure would have to be abandoned. But it was carried out. The patient's condition remained satisfactory throughout. The lowest blood pressure was 80/60, but the peripheral veins were full and the color of the patient remained pink. Fullness of veins and pink color continued during the rest of the operative day. The patient's recovery was smooth. The only complication was an intra-abdominal abscess which was opened on the seventeenth postoperative day. It is not probable that an operative procedure of this type and of this extent would usually be followed by such smooth immediate and late recovery.

CASE THREE

The first shock case was a 63-year old woman. Choledochoduodenostomy had been done for stricture of the papilla duodeni.† On the day of the operation and on the first postoperative day, her condition was satisfactory, with no unusual features. On the morning of the second postoperative day, she was cyanotic, her extremities cold and clammy; there was no perceptible peripheral pulse and no measurable blood pressure. She complained of feeling faint and of abdominal pain. She did not vomit. The abdomen seemed to be moderately rigid. General measures were started to relieve shock. A hypodermic injection of epinephrine was given; a cut-down was effected and Levophed® infusion was started by the cut-down. One pint of blood was transfused by a second cut-down. A catheter was placed into the bladder. By 3 p.m. the infusion containing one ampule of Levophed® was completed and one pint of blood was infused. Her condition did not improve. General appearance remained poor, extremities cold and clammy; no perceptible pulse; she had no urine secretion for four hours; she was somnolent.

Hibernation was started at 3 p.m. Her pulse rate at that time was 160 by counting the heart sounds and her respiratory rate was 44. Thirty minutes after starting the hibernation a few drops of urine appeared at the catheter. In 75 minutes about 30 cubic centimeters of urine were excreted. At 7 p.m. blood pressure was 102/60, the respiratory rate 30. Temperature rose to 103. Then two ice bags were applied. The hibernation was interrupted at 9 p.m. The next morning the patient was re-examined. Ninety cubic centimeters of urine had been excreted from 3 p.m. of the previous day until 9 a.m. Blood pressure was 80/60, the temperature was 101.2, the pulse rate 120, and the respiratory rate 28. During the day hibernation was continued. By the end of the day, 300 cubic centimeters of urine had been excreted. Blood pressure was 120/74, temperature 99.6, and the respiratory rate 20. She appeared well stabilized and she was out of shock. Four hours after start of the hibernation the extremities were dry, warm and pink and the peripheral veins were full. This was in dramatic contrast to the cold, clammy and cyanotic extremities and the collapsed veins when beginning the hibernation.

The cause of shock was determined later: the choledochoduodenostomy suture broke down, duodenal contents poured into the peritoneal cavity. The patient recovered fully from shock. But a duodenal fistula developed and she eventually died of this.

CASE FOUR

The second shock case was a 41-year old woman, who was dying from purulent generalized peritonitis and from subphrenic abscess. Twelve hours before death she went into deep shock. She was anuric. Hibernating drugs were given. She did not came out of shock but the anuria was temporarily reversed and urine secretion reappeared for several hours.

SUMMARY

(1) Hibernation seemed to stabilize the course in the two surgical cases. They persistently had pink color and full veins; their postoperative course seemed to be very smooth.

(2) Striking improvement occurred in the color and filling of the veins. Improvement of central and peripheral circulation and very prompt reappearance of urine secretion were impressive features in the first shock case. The urine secretion reappeared temporarily in the second shock case also.

(3) On the basis of this very limited experience it seems that favorable reports of the French medical literature are realistic; and that the method deserves further evaluation and clinical use.

†The papilla of Vater.

650 North Broad Street

Historical Article • • •

FRED B. ROGERS, M.D.*

Trenton

Israel Clarke of Clarkesville (1759-1837):

Witty Practitioner

Motorists driving along Route 1 pass a little cluster of buildings identified as Clarkesville. This is where Israel Clarke practiced medicine early in the 19th century. A pleasant vignette of that witty physician is here offered by Dr. Rogers.

THE medical profession, through the ages, has included in its number many versatile and unusual personalities; some are remembered, others forgotten. Individualism, bordering on occasion upon eccentricity, has betrayed talent in some doctors—as humor and humanity are closely allied in the healing art. Dr. Francois Rabelais (1490-1553) was probably the greatest joker of all time. His contemporary, Andrew Borde, physician to Henry VIII of England, laughingly observed that "Mirth is the best physick." Later, Sydenham, Garth and Goldsmith were noted for their quixotic views—combined with deep human sympathy. Oliver Wendell Holmes and William Osler, physicians less remote in time, each admired Rabelais and, like him, enjoyed an occasional jest. In colonial America, a Dr. Alexander Hamilton of Annapolis, Maryland, who kept an account of his *itinerarium* in 1744 along the Eastern Seaboard, was also a convivial spirit. Shortly after his trip through New Jersey, Dr. Israel Clarke, an obscure practitioner for whom the present Clarkesville is named, was well known locally for his humorous qualities. A few facts assembled from remote sources permits us to present a vignette of Dr. Clarke and the rural America of his day.

Clarkesville, a cluster of buildings at the intersection of U. S. Route One and the Quaker Bridge Road, southeast of Princeton, is hardly noticed today by the motorist hurrying to New York. It was here, however, that Israel Clarke lived and practiced medicine for over thirty years after 1800. He also operated a hotel near the site of an earlier inn; this spot was profitable because of stagecoach traffic and other travel over the Trenton turnpike, and was a good location for blacksmiths and wheelwrights. Gordon's *Gazetteer of New Jersey* (1834) described the place almost as it is today: "Clarkesville, small hamlet of West Windsor township, Middlesex County† on the straight turnpike road from Trenton to New Brunswick, 7 miles from the one, and 18 S. W. from the other; contains 2 taverns, and 6 or 8 dwellings; soil good, and country pleasant around it."

The Clarke family had been in New Jersey for over a century when the doctor settled at Clarkesville about 1800. His forebear, Benjamin Clarke, a native of Scotland, had joined the Religious Society of Friends soon after

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†Clarkesville is now in Mercer County. This county was created in 1838 by taking parts from adjacent counties.

its organization. He was a stationer in Lombard Street, London, prior to emigration to this country in 1683. He settled at Perth Amboy where, with his wife, he operated a bookshop. Their son, Benjamin, a surveyor by trade, moved to Stony Brook (now Princeton) from Piscataway in Middlesex County in 1695. Here he bought a large tract of land, including what was to become the Revolutionary battlefield at Princeton. Benjamin Clarke and his children were buried in the Quaker graveyard at Stony Brook. He was the grandfather of Dr. Israel Clarke, who was born in 1759 on the family farm near Princeton.



Figure 1. Stony Brook Meeting House. Woodcut by A. Ross Pittman, M.D.

Israel Clarke forswore his Quaker principles to serve in the Revolutionary War. Military records in the Adjutant General's Office at Trenton note: "Clarke, Israel, Doctor. Middlesex County. Born 1759. Private in Captain Philip Phillip's Volunteer Company, Major Eph. Anderson's Battalion, First Reg't. Hunterdon County Militia about Dec. 10, 1776." We can imagine that the seventeen-year old militiaman witnessed historic events about the rolling country near Princeton, in "the Cockpit of the Revolution." Washington's tattered column moved along the Quaker Bridge Road on the fateful night march from success at Trenton to victory at Princeton. This road was originally used by Friends travelling between their meetings at Stony Brook and Crosswicks—through the crossroads later called Clarkesville.

After his military service, Clarke studied medicine and became a country doctor. His preceptor's name and record of license to practice or academic degree have not been found. He did not become a member of The Medical Society of New Jersey or a County Medical Society, and is not mentioned in contemporary records of these bodies. In 1788 he married Susanna Johnes, kinswoman to Nathaniel Fitz-Randolph—the Quaker whose gift of land gave Princeton University its present campus. Fitz-Randolph's remains now rest in an ancient burying ground beneath Holder Hall (where a memorial tablet in the east entry now recalls his memory). Mrs. Clarke died three years later, leaving a son, James, who was subsequently graduated from Princeton College in 1806. James studied medicine with Dr. Nicholas Belleville of Trenton, and married his preceptor's daughter, Mary. In the East plot of the Lawrenceville Presbyterian Churchyard today, one can read the sad epitaph to the Doctor's wife: "In Memory of Susanna Clarke, wife of Doctor Israel Clarke, who departed this Life, April 13th, 1791. Aged 25 years."

Dr. Clarke began medical practice at Clarkesville several years after the death of his first wife. John Hageman, a local historian, in 1879 recalled that the doctor was "well remembered by our older inhabitants for his extensive practice and humorous nature." The historian added in 1883 that, "He practiced at Clarkesville, where he settled, and where he died. As a physician he was quite celebrated in the counties adjoining his extensive practice. He was full of humor, and had a day in the week fixed for office business, when great crowds flocked to consult him. Clarkesville is called after him. George W. Applegate now lives on his former residence. Dr. James Clarke of Trenton was his son." (The one-day-a-week routine might jokingly be misconstrued as the ideal of a few modern medical specialists!)

FROM entries in the *New Jersey Archives*, we know that Dr. Clarke was an extensive landowner in and about Princeton. He remarried seventeen years after the death of his first wife. The *Trenton Federalist* for July

11, 1808 noted: "Married on the 2nd inst. at Maidenhead (Lawrenceville) by the Rev'd Mr. Brown, Doct. Israel Clarke to Miss Betsy Vancleve, daughter of Benjamin Vancleve, Esq. of that township." Two daughters came from this union: Mary, who married Dr. Alexander Hart of Philadelphia, and Elizabeth.

There was a clash of family interests pertaining to the will of Benjamin Van Cleve, father-in-law to Dr. Clarke, who died in 1817. This provoked a legal controversy of considerable public interest at the time. Chancellor Edwin R. Walker of the New Jersey Supreme Court, great-great grandson of Van Cleve, reviewed this interesting case in 1927. Benjamin Van Cleve, Revolutionary soldier and State Legislator, was a prosperous farmer at Lawrenceville. During his last illness, a paralytic stroke, he willed his estate to his son, Joseph, to the exclusion of his two daughters. The daughters, joined by their husbands—Dr. Israel Clarke and Major John Stevens—initiated a court action which lasted four years, with lawsuits in State and Federal courts. During this fierce contest, Dr. Clarke, the testator's son-in-law and physician, and Dr. Nicholas Belleville of Trenton, brother-in-law to Dr. Clarke, were called, among others, for their testimony on Van Cleve's fatal illness. The case was heard before the New Jersey Supreme Court in November 1818, and then tried in the United States Circuit Court for Hunterdon District during the April term of 1822. Justice Bushrod Washington of the U. S. Supreme Court, and Judge William S. Pennington of the New Jersey District Court presided. The case, in legal parlance, was "an action of ejectment, Jon Den (a fictitious person) on demise, of Dr. Israel Clarke and wife, and of Major John Stevens and wife, against Joseph W. Van Cleve." This irregular suit was decided in favor of the son and heir, who inherited his father's farm at Lawrenceville. According to Chancellor Walker, the daughters reflected no credit upon themselves by this unnatural litigation. Justice triumphed, but the concluding decision was a bitter disappointment to the losing side. The vicissitudes of lawsuits during the four-year dispute, which were costly to all parties, resulted in an unhappy estrangement of relatives.

Doctor Clarke continued his busy medical practice until late in life. He was a prosperous and respected citizen, well known locally for his professional skill and wit. He died at his home in Clarkesville on May 19, 1837, and was interred in the ancestral burial ground at Stony Brook. His passing was noted in the *New Jersey State Gazette* (Trenton) of May 26. The *Princeton Whig* for June 2, 1837, printed the following tribute:

> "Died, on Friday, the 19th ult. at his residence, about 5 miles South of this borough, in the 78th year of his age, Doctor Israel Clarke, long an able practitioner, and highly respectable citizen of this vicinity. His funeral bore some evidence of the high estimation in which he was held by the surrounding country; it was one of the very largest we remember to have attended, but entirely without any ostentation or attempt at display."

Today, his home, a white frame farmhouse, still stands at Clarkesville—the crossroad hamlet which bears his name. An unmarked grave in the Stony Brook Friend's Burial Ground at Princeton holds the remains of this witty practitioner of yesteryear. Guarded by songbirds in summer and snowfall in winter, his remains rest in the pastoral spot where he lived and practiced his profession long ago.

2200 Hamilton Avenue

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Board of Trustees Meeting, March 2, 1958

At its March 2, 1958 session, the Trustees:

—Considered the question of the propriety and legality of intravenous medication by nurses, and adopted the following resolution:

Resolved, that in hospitals approved and licensed by the New Jersey State Department of Institutions and Agencies, the administration of intravenous therapy, and/or transfusions and/or the conduct of certain other technical procedures by a nurse or other technician certified by the head of the medical staff and the director of the respective hospital as having had adequate previous training in the administration of such therapy, and/or the conduct of such procedures shall be regarded by the Board of Trustees of The Medical Society of New Jersey as having been carried out under the immediate supervision of a licensed physician, and shall not be deemed to be in contravention of the Medical Practice Act of New Jersey.

—Approved a procedural and organizational Code for Hearing and Speech Centers.

—Reaffirmed the principle of "service benefits" in the Medicare Program and instructed our Special Committee to be guided by this policy.

—Authorized a reception for Dr. and Mrs. Allman on the evening of the first day of the Annual Meeting.

—Confirmed the action of the President in authorizing the Health Insurance Council to send some pamphlets on health insurance to the membership.

—Referred to the Special Committee on Hearing and Speech a proposal that we recommend establishment of an Audiology department in a New Jersey University.

—Directed that the component societies be notified of the attendance record of their representatives at Welfare Committee sessions.

—Approved Assembly Bill A-532; took a "no action" position on S-291; and approved SR-6 provided distribution be limited to medically indigent persons.

—Adopted the following recommendation with reference to the eye health screening program:

That a double postal card be sent to all individuals screened found to possess abnormalities—one section of the postal to remind the addressee that six months have elapsed since the examination and remind him to make contact with his ophthalmologist if he has not already done so, the other half to be completed and returned to the Executive Offices indicating whether or not he has seen or will see his ophthalmologist, and the name of the latter; returns then to be followed up by contact with the ophthalmologist as to his findings.

—Requested the Department of Institutions and Agencies to amend Item 6 in its *Nursing Home Guide* to read: "A physician shall be called in emergencies. Bodies of deceased persons shall not be released to the undertaker until death has been certified by a physician"; and that the amended version—if accepted by the Department—be referred to the Publication Committee for consideration for The Journal.

—Heard the report of the Medico-Legal Testimony Committee which included the following:

"It was reported to the committee that the Judiciary is disappointed that the Society is not doing something toward providing medical testimony in professional liability cases. The committee devoted two years in an effort to reach a solution agreeable to the Bar Association and our insurance carrier. The Bar Association represents only a small part of the lawyers in the state, most of whom are not interested in this type of case; the non-member lawyers are the ones who take these cases, and there is no way in which to reach them as a group. The insurance carrier is satisfied with the present system."

The Board discussed whether the Judiciary should be informed of the efforts the Society has made in an attempt to provide medical testimony in professional liability cases and the opposition met to the methods proposed.

It was moved and carried that nothing be done at this time.

—Received the report of the Medicare Committee, including the following items:

1. The committee was requested to submit fees covering psychiatric care for dependents with acute emotional disorders. With the assistance of the New Jersey Neuropsychiatric Association, suggested fees were determined and submitted to Washington. Request was made for authorization to have the current contract amended accordingly. This request was approved.

2. Four supplemental agreements to amend the contract were received from the Department of Defense. With the concurrence of the Chairman of the Board of Trustees, and with the approval of the special committee, they were processed for signatures in the Society and Medical Service Administration. They covered (1) Annual settlement of administrative cost, (2) Dental procedures and treatment of injuries when patient is not hospitalized, (3) Maximum "Allowable Cost" for committee expenses reimburseable from the U. S. Government, and (4) Deletion of word "hospital" from code 1917 and word "office" from code 1916. These actions were approved.

3. The committee saw no immediate need to communicate with the Government requesting a uniform definition of "cost per claim." Materials from Washington indicate that uniformity will soon be established. The matter has been discussed with representatives of Medicare who visited New Jersey and they agreed such uniformity is desirable. If such has not been established by the re-negotiation date, the committee will present the request at that time.

—Heard a report on the N. J. Consultation Service for Convulsive Disorders. This report detailed the program of the service, the experience of the four existing clinics, reasons for establishment of a fifth clinic in Essex County, and explained that the term "Convulsive Disorders" was adopted at the suggestion of the Advisory Council as a socially more acceptable designation than "Epilepsy" —although coverage is not extended beyond epilepsy.

The report was accepted. The Board concurred that the Essex County Medical Society extend cooperation to the service as requested, and that a copy of the report be sent to Essex County.

—Received a report that the New Jersey Blood Bank Commission had investigated the use in New Jersey made of the Northeastern District Clearing House sponsored by the Blood Bank Association of New York. Use of the Clearing House during 1957 in New Jersey was small and limited to three blood banks. It was the feeling of the Commission that until the program receives more adequate publicity, New Jersey should not be expected to support financially an altogether unfamiliar program. However, the Commission recommended that as a token of support and in recognition of the small use of the program by New Jersey residents to date, a $100 contribution be made. The Trustees voted to make this contribution.

—Authorized the special Veterans Administration Committee to negotiate a fee schedule with that agency.

—Directed that the Subcommittee on Legislation restudy bill A-70, which would provide hospital, medical, and surgical benefits to state employees, with the cost to be paid by the State. These paragraphs would set the income limit at $5,000, and would legislate the 1949 MSP schedule of benefits. The Subcommittee on Legislation had previously endorsed the principle of this legislation. It was considered, however, that professional fees cannot be legislated, and any such plan should provide for participating physicians' agreement, and an up-to-date income limit and schedule of benefits.

Dr. Comando in Blue Shield Post

Appointment of Dr. Harry N. Comando, Newark surgeon, as director of professional relations for Medical-Surgical Plan of New Jersey (Blue Shield) has been announced.

Dr. Comando has retired from active practice and from the Board of Trustees of Blue Shield to accept this post. A physician in Newark for 46 years, he was one of the original trustees of the Medical-Surgical Plan when it was organized in 1942 under auspices of The Medical Society of New Jersey; and until his resignation from the Board was first vice-president.

Dr. Comando will be in charge of relations with New Jersey Blue Shield's 6,000 participating physicians. He will develop contact with hospital medical staffs and members of the medical profession throughout the state. About 80 per cent of New Jersey's physicians are already on a participating basis with the plan, which has a total enrollment of nearly 1,700,000 individuals. Last year, New Jersey Blue Shield incurred a record $22,866,253 on doctor bills of its subscribers.

Dr. Comando received his M.D. degree at Medico-Chirurgical College of Philadelphia in 1912. He has practiced in Newark since completing his internship at Newark City Hospital

in 1914 and for many years was on the surgical staffs of Newark Beth Israel, Irvington General, Presbyterian, and St. Barnabas hospitals, as well as the Martland Medical Center.

Dr. Comando is a past president of the Society of Surgeons of New Jersey, the New Jersey Pathologic and Anatomic Society, the Academy of Medicine of New Jersey, and the Essex County Medical Society. He is a founder of the International College of Surgeons, a Fellow of the American College of Surgeons and the Society of Surgeons of New Jersey, and a diplomate of the American Board of Surgery.

Dr. Comando resides at 67 South Munn Avenue, East Orange.

Guide for Medical Care and Medical Records in Nursing Homes

As a guide to good medical care in nursing homes, the following is issued and, at the request of our Board of Trustees, published in this JOURNAL:

(Excerpt from the Manual of the Department of Institutions and Agencies)

MEDICAL CARE

1. Every patient in a nursing home shall be under the care of a physician licensed to practice medicine in New Jersey.
2. The medical services provided shall in turn limit admission to those for whom service is available.
3. All medical orders shall be signed by the attending physician.
4. A complete physical examination shall be done upon admission.
5. There shall be provision for specialists' services, laboratory and x-ray work as needed. In rare instances the large nursing home may wish to provide x-ray equipment. However, it is strongly advised that this service be secured by formal arrangement with a local hospital since it is not practical or efficient in the average nursing home.
6. A physician shall be called in emergencies. Bodies of deceased persons shall not be released to the undertaker until death has been certified by the physician.
7. Death certificate stubs or copies of death certificates shall be kept on file.
8. Provision should be made for regular dental care as well as dental service in an emergency.
9. Patients should be permitted free choice of a physician.
10. The nursing home operator shall be responsible for making an arrangement with a doctor to be available for emergencies.
11. The operator shall also establish a procedure for securing a doctor and effecting the transfer of a patient to a hospital or other facility as promptly as needed.
12. The physician shall visit the patient as often as necessary to assure adequate medical care.

MEDICAL RECORDS

1. History and physical on admission
2. Progress notes
3. Written orders signed by a physician for all medications and treatments
4. Signed record of any x-ray or laboratory findings.

NURSES' RECORDS

Pertinent data relating the general condition of patients, special treatments and special medications shall be recorded. This can be done by maintaining individual patient charts or by Day and Night Report Record. In all instances, a detailed report is required on acutely ill, temporarily disturbed, and terminal cases.

A card index or other similar system should be used as a safeguard in the dispensing of medications.

NARCOTIC AND HYPNOTIC RECORD

All such drugs shall be recorded on an individual patient prescription. It is suggested that an index be used to identify each patient.

Annual Report of Morris County Medical Society*

Robert F. Zimmerman, M.D., President, Morristown

The fiscal year of the Morris County Medical Society started with the annual meeting on June 20, 1957 at the Spring Brook Country Club. The usual golf tournament proved to be a great success. Dinner and the election of officers followed.

The October meeting was addressed by Mr. William Coleman of the Automotive Crash Injury Research Center of Cornell University. His talk was most informative. A committee to further study the formation of a Woman's Auxiliary was appointed at this meeting. Revival of the Rutgers Extension Courses (discontinued during World War II), was approved and the first series is under way.

Dr. Lyndon A. Peer spoke at the November meeting to which the members of the Tri-County Dental Society had been invited. "The Experimental Production of Congenital Deformities and Use of Homografts in Treatment" was extremely stimulating.

The January dinner meeting was highlighted by the presentation of Golden Merit Awards to Drs. George H. Lathrope, William A. McMurtrie, Bernard C. McMahon, and William F. Costello. Dr. F. Clyde Bowers, representing President Kump of The Medical Society of New Jersey, made the presentation speech. Mrs. John Voss, President of the State Auxiliary, spoke briefly on the advantages of membership in this organization.

The George H. Lathrope Lecture on "The Role of Fats and Cholesterol in Atherosclerosis" was delivered by Dr. Theodore van Itallie at the February meeting. As President I have noted little, if any, reduction in the waistlines of our membership, even though this lecture was very well attended and received.

In March we were literally "snowed out" and our meeting had to be cancelled.

At the April session, our speaker was Dr. Felix Wroblewski of Memorial Hospital, New York City. He spoke on "Role of Blood Enzyme Studies in Diagnosis of Neoplasms, Coronary and Other Diseases."

I would be very remiss if I did not note the severe loss we have suffered in the passing of Dr. Stanley Teskey. We quote from the *Bernardsville News* which expresses so well the feeling of the Morris County Medical Society:

"Although it was widely known that Dr. Stanley Teskey was seriously ill, his death Friday came as a shock to the many friends he made professionally and personally since he came to Bernardsville, 27 years ago. His death brought on a widespread realization that a sudden void had been created in the life of the community which will be difficult to fill.

"Dr. Teskey's life was truly dedicated to helping his fellow being. His calling was in the field of medicine which demands so much in time and energy, but Dr. Teskey did not hesitate to serve the community in other areas. His services on the Board of Education, the Board of Health, the YMCA, the Rotary Club and the First Aid Squad were manifestations that Dr. Teskey had a genuine interest in others.

"Dr Teskey was the type of man that no community can afford to lose."

The presidency of a county society is indeed an honor and a privilege but without the help of the Executive Committee, and particularly of the Secretary and Executive Secretary, this work could hardly have been carried on. All honor to these.

*Received too late for our May issue.

Medical Bibliography Available

The U. S. Department of Health, Education and Welfare announces that the National Library of Medicine has released the third annual volume of its *Bibliography of Medical Reviews*. This includes about 3000 review articles in all phases of medicine. The volume is arranged by subject with a separate author index and contains references to review articles in clinical and experimental medicine and allied fields which have appeared in 1957. Copies of Volume 3 for 1958 are now available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at $1.25.

Obituaries • • •

DR. THOMAS KEEGAN

At the grand old age of 78, Dr. Thomas Keegan died at the Jersey City Medical Center on April 25. Born in Jersey City in 1879, Thomas Keegan was graduated from State Teachers' College in 1899. He taught for 2 years, then entered the medical school of Columbia University, from which he was graduated in 1904. Dr. Keegan was a family doctor in the best sense of that word. For 22 years he was president of the Hudson County Board of Health. He was an emeritus member of the Hudson County Medical Society and only last year he received the Golden Merit award of The Medical Society of New Jersey.

DR. ARTHUR LIGHT

Dr. Arthur Light, medical director of the Lawrenceville School died the first day of spring. Born in 1893, Dr. Light obtained his M.D. from the University of Pennsylvania in 1918. His first interest was medical psychology, and he was a pioneer in teaching that subject at the University of Pennsylvania from 1920 to 1926. Then he developed an increasing concern with the medical and health aspects of sports and athletics. He soon became medical director of the University's intercollegiate athletic program. In 1930 he was awarded a Rockefeller Fellowship for the study of drug habituation and, under Foundation auspices, co-authored a book on Opium Addiction. He also had a summer private practice at Bay Head. At the conclusion of his Rockefeller project, he was designated medical director of the Lawrenceville School, a position which he held until his death in March 1958.

DR. RICHARD J. McDONALD

St. Joseph Hospital lost its chief of dermatology on March 12 with the death that day of Dr. Richard J. McDonald. Born in Chicago, Dr. McDonald moved to Paterson in childhood. In 1913 he won his M.D. from Georgetown University School of Medicine. He then interned in St. Joseph Hospital, and moved to Butler, N. J., where, for a decade, he was in general practice. He then devoted two years to advanced study in dermatology, returning to Paterson to practice that specialty. He was a diplomate of the American Board of Dermatology and Syphilology and active in the New York Academy of Medicine. He was vice-president of the First National Bank of Butler. Dr. McDonald was 67 years old at the time of his death.

DR. ALBERICO MASUCCI

A coronary attack took the life of Dr. Alberico Masucci on April 18. A 1930 graduate of the medical school of Boston University, Dr. Masucci was only 49 years old at the time of his death. He was active in the affairs of the Passaic County Medical Society and had practiced for two decades in his native Paterson. Long interested in surgery, Dr. Masucci was a Fellow of the American College of Surgeons and on the surgical staff of the St. Joseph Hospital in Paterson.

DR. CARLYLE MORRIS

Death came to Dr. Carlyle Morris on April 10. Dr. Morris was active in committee work in The Medical Society of New Jersey. He served the Middlesex County Medical Society in all its offices, including a term as its president. He was also a president of the Metuchen Rotary Club, and a founder of the local American Legion post.

Carlyle Morris was born in North Carolina in 1894. In 1922 he won his M.D. at the University of Pennsylvania and then did graduate work at Harvard. He came to Metuchen in 1928 and has been serving the people of Middlesex County ever since. He was on the staff of the Muhlenburg Hospital. Dr. Morris saw military service in both world wars—as an enlisted man in France in 1918; as a major in the medical corps in the Pacific in 1943-4. Dr. Morris was a diplomate of the American Board of Internal Medicine.

DR. MARTIN NEMIROW

After serving the people of Passaic for almost a half century, Dr. Martin Nemirow died on April 17 at St. Mary's Hospital. Born in Russia in 1881, Martin Nemirow earned a B.S. in chemistry in that country in 1903; he then went on to Germany where he received a Ph.D. in chemistry in 1905. He first planned a musical career and had two years at the famous Shavenca Conservatory. Then he came to the United States where, in 1911, he received his M.D. degree from New York Eclectic. Dr. Nemirow was a general practitioner, a family doctor of the old school. He was active in the local unit of the American Academy of General Practice and was affiliated with the Passaic General Hospital.

DR. ERNEST F. PURCELL, JR.

On April 5, death brought a premature and untimely end to the promising career of Dr. Ernest F. Purcell, Jr. Born in Trenton in 1921, Dr. Purcell was a graduate of the medical college of New York University, class of 1947. He then served with the Army Medical Corps in Korea and Japan. Returning to Trenton, he became interested in anesthesiology, and at the time of his death, he was assistant chief of anesthesiology at McKinley Hospital. He was active in the affairs of the Mercer County Medical Society. Dr. Purcell was a Fellow of the American College of Anesthesiologists and a Trustee of the Ewing Presbyterian Church.

DR. LEO SALVATI

One of Union County's leading surgeons, Dr. Leo Salvati, died on February 20, following a heart attack. Born in 1897, Dr. Salvati was graduated in 1924 from the medical school of the University of Maryland. He interned at Muhlenberg Hospital, and then joined the staff as a clinical assistant in 1926. By 1937 he had become an attending surgeon. He served in the Navy in World War I. He was treasurer of the Society of Surgeons of New Jersey and was chairman of Westfield's Brotherhood Week. A fund for cancer research was established in his memory at the Muhlenberg Hospital. Dr. Salvati was an FACS and he was active in the work of the Union County Medical Society.

DR. LOUIS H. ROBINSON

Those of us who had offices in the Medical Towers will remember Louis Robinson. Every noon-time found him at a back table at Barbarosh's Pharmacy, cheering us up with humor—sometimes dry, sometimes salty. You could never get him down. He would tease without being malicious, and he was a bright spot in any day, no matter how gloomy.

Louis Robinson died on the first day of spring. He was 75 years old and had been living in Florida since he suffered a stroke in 1956. A graduate of the old Long Island College Hospital, he had maintained offices in Newark from 1916. He was a charter tenant at Medical Towers—possibly the first doctor to move into that building while the paint was still wet on the walls. The Towers will never quite seem the same now.

DR. MILTON SHANGLE

One of New Jersey's best known surgeons died on February 7. He was Dr. Milton Shangle, formerly chief of staff at Elizabeth General Hospital. Dr. Shangle was a native of and a resident of Union County. He was graduated in 1900 from Columbia University's College of Physicians and Surgeons. He interned at Elizabeth General and remained identified with that hospital for the rest of his professional life. He started there as an assistant clinic physician and passed through all grades, becoming senior attending surgeon, later president of the medical board, and eventually chief of staff. Shangle Hall at the hospital was named for him in commemoration of a half-century of service to the General Hospital. During World War I he was at the Fort Dix Station Hospital and was, at one time, its commanding officer. Dr. Shangle had been president of the New Jersey Society of Surgeons and was a diplomate of the American Board of Surgery.

Road Toll

One out of every 67 Americans was killed or injured in an automobile crash last year. Total casualties were 2,563,700, the highest total in history.

Driver error accounted for most of the accidents. Excessive speeding was the greatest single error. A total of 13,200 died and 837,000 were injured in speeding accidents alone.

Over 95 per cent of the vehicles involved in accidents were in apparently good condition. More than 85 per cent of the fatal accidents came during clear weather, 80 per cent on dry roads. These facts emphasize the factor of driver responsibility.

More than 26 per cent of the drivers in fatal crashes were under 25 years of age. On the other hand, 97 per cent of the fatal accident drivers had over one year's driving experience.

Pedestrian fatalities reached 7,500 and injuries reached 22,200. These figures were slightly below the 1956 totals. Over 34 per cent of the pedestrian deaths resulted from crossing in the middle of the block.

Announcements • • •

Gastroenterology Course

A course in gastroenterology will be given at the Jung Hotel in New Orleans on October 23, 24 and 25, 1958. It will be under the direction of Dr. Owen H. Wangensteen and Dr. I. Snapper. They will be assisted by a distinguished faculty. The course will cover diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gall bladder, colon and rectum.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Course in Occupational Medicine

Occupational Medicine, a full-time course for practicing physicians, will be given from September 15 through November 7, 1958 by the New York Post-Graduate Medical School. The course includes epidemiology, biostatistics, administrative medicine, occupational diseases, and industrial hygiene. Didactic instruction will be supplemented with field trips to industrial health plants, governmental agencies concerned with industrial health and to union health centers. Opportunity will be given to attend conferences in several specialties at the Bellevue Medical Center.

For further information write: Office of the Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Ophthalmology Course

The Institute of Ophthalmology of the New York Eye and Ear Infirmary announces graduate courses for specialists to be given from November 3, 1958 to January 9, 1959. Courses will be given in: anomalies of extraocular muscles, biomicroscopy, cataracts, bacteriology, ophthalmic surgery, electrophysiology, glaucoma, biomicroscopy, allergy, biochemistry, microbiology, neuro-ophthalmology, ocular photography, radiology, ocular trauma, ophthalmoscopy, perimetry, plastic surgery, pleoptics, psychosomatic factors, radio-isotopes in ophthalmology, and refraction.

Further information is obtained from Registrar, Institute of Ophthalmology, New York Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Communication Charts for Aphasics

A unique "Hand Talking Chart" which enables aphasic people to communicate is available from the doctor who designed it. He is Dr. Hamilton Cameron, 601 West 110th Street, New York 25, N. Y. These charts sell at $4.00 a copy for the 11 by 14 size, and $7.00 a copy for the giant 30 by 30 inch chart, which rapidly teaches the aphasic how to use hand signals in order to communicate. The charts may be obtained by sending remittance directly to Dr. Cameron.

New Obstetrics-Gynecology Series

Paul Hoeber, Inc. announces the availability of a series of books on gynecologic and obstetric practice. Known as *Clinical Obstetrics and Gynecology*, each book includes one monograph in obstetrics and one in gynecology. Emphasis is on practical applications. The set is available at an annual subscription of $18. This, in effect, gives the practitioner four double books or eight monographs a year. More details are available from Paul B. Hoeber at 49 East 33 Street, New York 16, N. Y.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on February 14, 1958. The business meeting preceded the scientific program because of the many guests present, which included members of the Atlantic County Dental Society.

Dr. Thomas P. McFarland was approved for Regular membership by transfer from the Philadelphia County Medical Society.

The Committee recommended the approval of Paul Lin for courtesy membership in the Society. The Society then approved the recommendation of the Committee.

The Committee on Graduate Education made the following recommendations:

1. That the Society recognize the Visiting Chief Program of the Atlantic City Hospital as acceptable for its Graduate Education accreditation.
2. That the Chairman of the Committee be authorized to send post cards to the members of the society, informing them of the weekly program.
3. That the Society present a certificate to every member completing fifty hours of attendance, at the Visiting Chief conferences, in any one year.

The Scientific program was then presented. The speaker was M. Harris Samitz, M.D., Assistant Professor of Dermatology at the University of Pennsylvania. The presentation, including some excellent slides, was well received. The subject was "Medical-Dermatological Oral Syndromes." Dr. Walker thanked the speaker for the fine presentation.

The regular meeting of the *Medical Society of Atlantic County* was held on March 14 at the Children's Seashore House. President Levi Walker opened the meeting and asked Dr. James Mason, 3rd to introduce the speaker.

The speaker was Mark M. Ravitch, M.D., Associate Professor of Surgery, Johns Hopkins University. His subject was "The Surgical Approach to Chronic Non-Specific Ulcerative Colitis."

The paper was discussed by Dr. McCracken and the speaker was thanked for the presentation by Dr. Mason and Dr. Allman.

The business meeting was conducted by Dr. Walker. Dr. Molitch reviewed the graduate course during the past two weeks and encouraged members to attend the "visiting chief" program. Dr. Molitch also urged doctors to avoid the frequent renewal of prescriptions for "welfare" patients. He urged all doctors to order greater amounts with the original prescription so that renewals will not have to be necessary and also asked physicians to make sure that renewals were not made without the permission of the physician.

Dr. Donald Davidson made an appeal for doctors to save their samples of vitamins so they could be collected for missionary work.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society,* held April 8 at Bergen Pines Hospital, Paramus, was called to order by L. J. Fitzpatrick, M.D., President, at 9:06 p.m., a quorum being present. The total attendance before adjournment was 60 members.

The Secretary read the following names, which had been approved by the Executive Committee for election:

To Regular from Associate—Rudolf Frank; To Regular by transfer—J. Timothy Donovan from New York Co. Med. Soc.; To Associate—A. F. Bonacarti and John P. Lauricella; To Courtesy from Regular—Ralph B. Maffey; To Emeritus—Walter W. Mockett.

The Secretary was instructed to cast one ballot for the election of this panel.

The Secretary announced that hospital administrations were no longer able to extend courtesy reductions to physicians, and, therefore, to avoid paying full rates, it behooved every doctor to carry Blue Cross.

The President announced changes by appointment in the list of Delegates and Alternates to the 1958 Annual Meeting.

The Secretary reminded the members of the importance of returning the questionnaires on professional liability insurance from the State Medical Society Committee to help complete a survey of the members with a view to improving coverage and perhaps lowering rates. These questionnaires were mailed to everyone with the latest Membership New Letter of M. S. of N. J.

Dr. Worcester read a letter from the Legislative Committee to the Executive Committee about opposition to New Jersey Assembly Bill A-178; he then read a resolution proposed jointly by the Legislative and Conservation of Vision Committees and successfully moved its adoption.

Dr. Knight, chairman of the Nominating Committee, placed the following names in nomination for the Society officers indicated: For the year 1958-1959: President—Dr. George Heller; First Vice-President—Dr. Donald B. Hull; Second Vice-

President—Dr. George O. Rowohlt; Secretary—Dr. Charles P. Campbell; Treasurer—Dr. John P. O'Connor; Assistant Treasurer—Dr. Alfred A. Alessi; Member of the Judicial Committee—Dr. William T. Knight.

Dr. Roe, chairman of the Scientific Program Committee, introduced the speakers and the topic: "Reconstructive Plastic Surgery." The presentation began with a background story of plastic surgery, both ancient and recent, by Dr. M. Mayer; this was followed by case descriptions with slides by both Drs. Gossel and Mayer.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held on April 1, at Cherry Hill Inn, with President Dr. Ralph S. Wright, presiding.

Dr. Andrew F. Jannett was unanimously elected to membership.

Dr. Ralph K. Hollinshed was presented with a framed certificate honoring him for his fifty years in the practice of medicine. A similar certificate was presented to him on behalf of his sister, Dr. Beulah S. Hollinshed, for 51 years in the practice of medicine.

The Secretary advised Dr. Lester R. Wilson, Chairman of the Bond Drive, that the Society has just invested $10,000 in federal bonds.

The Program Committee presented a discussion of "Psychiatric Progress." Dr. Elic A. Denbo acted as moderator; Dr. Michael Mendelson, Assistant Director, New Jersey State Hospital at Ancora, discussed the physician's responsibility to the discharged mental patient; Dr. Daniel Stephenson talked about general hospital psychiatry; Dr. Vincent Mahoney discussed office psychiatry; Dr. Wallace Hussong spoke about community needs and facilities. An informative and spirited question and answer period followed.

There were 61 members present. The meeting adjourned at 10:40 p.m.

EUGENE H. KAIN, M.D.

Reporter

Cumberland

The April meeting of the *Cumberland County Medical Society* was held at the Buena Vista Country Club, Buena Vista, at 2:30 p.m., on the 8th day of the month, with Dr. Paul K. Ayars, the president, presiding. The annual election of officers resulted in the following selections:

President: Dr. M. David Baxter, Vineland; Vice-President: Dr. Benjamin Berkowitz, Bridgeton; Secretary: Dr. Mary Bacon, Bridgeton; Treasurer: Dr. Samuel B. Pole, III, Bridgeton; Reporter: Dr. Leonard G. Scott, Bridgeton. Elected to Executive Board for 1 year: Dr. Maurice Harris, Bridgeton; Dr. Edward J. Chmelewski, Millville; Dr. Harry A. Reinhart, Vineland. County Judicial Committee: Dr. Samuel B. Pole, III. Delegates to Medical Society of New Jersey: Dr. Mary Bacon, Dr. Paul K. Ayars, Port Norris. Alternates: Dr. Sidney L. Siegel, Millville; Dr. Richard Kerdasha, Vineland. Nominating Delegate: Dr. Carl N. Ware, Shiloh; Alternate: Dr. Mary Bacon. County Nominating Committee: Dr. Alfred O. Davies, Millville; Dr. Robert A. Levenson, Vineland; Dr. Sherman Garrison, Jr., Bridgeton.

A poll, concerning time, place and other circumstances of regular meetings resulted in 67 replies received of a possible 91 active members and substantiated the Society's vote to continue meetings on Tuesday, 2:30 p.m., with food; place to be arranged by the Program Chairman with the approval of the Executive Committee.

The resolution, concerning the "Use of Atomic Devices Against Civilian Population" approved in the December 10, 1957 meeting, has been received by the Board of Trustees of The Medical Society of New Jersey and referred to the House of Delegates.

It was noted that the Welfare Committee has had 100 per cent attendance and cooperation during the past year.

Dr. Mary Bacon gave a complete report of the Maternal Welfare Committee.

Among the committee reports called for by Dr. Ayars were the well explained resumes of the Veteran Affairs and Rehabilitation Committee by Dr. E. C. Green. He pointed out the Rehabilitation Commission suggested that county societies advise the organization of the various lay groups interested in this work to eradicate overlapping. Dr. Sherman Garrison, Jr., of the Disaster Committee, explained that each local hospital has its own particular setup in case of disaster. Cumberland County has a 300 bed mobile unit which might be used in case of an emergency. Dr. Nicholas Marchione, chairman of the General Practice Committee, reported the active educational program for the physicians of this county is being held at Newcomb Hospital, Vineland, N. J., through the efforts of Drs. Ruggieri, Thalheimer and Solomon.

The speaker, Dr. Charles H. de T. Shivers, Emeritus Professor of Urology, University of Pennsylvania Graduate School of Medicine, Immediate Past-President, American Urological Association, chose as his topic: "Urological Problems Confronting the General Practitioner." Dr. Shivers talked on the upper urinary tract diseases including, kidney stones and tumors of the kidneys and congenital deformities. He explained that many symptoms referrable to the kidneys are obscure and advised complete examinations and investigations by our modern methods in order to identify pathology. He pointed out that since the general practitioner sees this type of case initially, it is paramount

that he be well informed on the diagnosis, treatment and referrals indicated.

Dr. Shivers augmented his talk with actual cases from his files.

The meeting adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Harold Gorenberg presiding the *Hudson County Medical Society* held its regular meeting at Jersey City Medical Center on March 4, 1958. The following resolution was passed unanimously:

> *Whereas* the Medical-Surgical Plan has certain financial restrictions in the insurance plans they offer and
>
> *Whereas* it is believed these restrictions are frequently not adhered to, to the detriment of patients and physicians, therefore,
>
> *Be It Resolved* that the Medical-Surgical Plan of New Jersey be urgently requested to review this situation and institute strong measures to remedy it; to consider, among other measures deemed feasible, the use of a rigid financial statement form as part of the application procedure.

A motion was made and passed that all resolutions intended to be presented to the State Society be first referred to an appropriate committee and printed in the *Bulletin* before being voted upon by the Society.

Elected to active membership were Dr. Stanley Bresticker, Hoboken, Dr. Paul V. Cavalli, North Bergen, Dr. Joseph A. Feudi, North Bergen, Dr. Maceo McQueen Howard, Jersey City, Dr. Edward K. Madison, Washington, D.C., Dr. Spencer Munroe, Jersey City, Dr. Romulo G. Pittella, Jersey City, and Dr. Mary Ann Catherine Zlatnik, Newark.

Guest speaker was Dr. Louis Lasanga, Associate Professor of Pharmacology, Johns Hopkins University. His topic was "The Role of the Placebo in Medical Therapy."

MATTHEW E. BOYLAN, M.D.

Reporter

Middlesex

The March 19 meeting of the *Middlesex County Medical Society* was called to order by Dr. Gerard R. Gessner, the president, at 9:00 p.m. at the Roosevelt Hospital, Metuchen.

The guest speaker of the evening was Mr. William Braun, attorney for Faulhaber & Heard, Inc., the agency authorized to negotiate professional liability contracts for The Medical Society of New Jersey. He spoke on the increased numbers of lawsuits against doctors, pointing out the factors primarily responsible for this trend.

Dr. Samuel Breslow summarized the results of a meeting held to develop ways of solving problems which recently brought about a set-back in relations between the doctors and the First Aid Squads.

Drs. Joseph F. Sandella, W. E. Sherman, and Malcolm M. Dunham were appointed by the president to the 1958 Nominating Committee.

Dr. A. Fishkoff was appointed as a new delegate, with Dr. Robert C. Steinman as alternate to the State Society Convention. Dr. William Rubin was appointed alternate delegate to replace Dr. Howard Slobodien, who resigned at the February meeting.

The sum of $350 was unanimously voted towards the expenditure account to be used during The Medical Society of New Jersey's convention at Atlantic City in May, for maintaining the Middlesex County Medical Society delegation.

Dr. Charles H. Calvin reported for the Constitution and By-Laws Committee. Dr. B. F. Slobodien recommended that the definition of "Doctor of Medicine" be made very clear in the revised Constitution and By-Laws. It was agreed that the clauses relating to compulsory attendance be deleted.

Membership elections were voted upon and approved as follows: To regular membership from Associate membership: Dr. Harold W. Potter, Metuchen; Dr. Bernard Beuche, Spotswood; Dr. Kenneth S. Gould, New Brunswick.

To two-year Associate membership: Dr. Anthony M. Arangio, New Brunswick.

To regular membership by transfer from Bronx County Medical Society: Dr. Jacob Kirshner, New Brunswick.

To Regular membership by transfer from Chicago Medical Society: Dr. Francis J. Warner, New Brunswick.

Dr. J. V. Shull of Perth Amboy was recommended to Emeritus membership with cancellation of dues retroactive to the date of his disability. Approval was unanimous.

Dr. A. Fishkoff was appointed to present the resolution on Medical-Surgical Plan at the State Society's convention in Atlantic City. Dr. Fishkoff asked that copies of this resolution be sent to each County Medical Society in New Jersey.

Meeting was adjourned at 11:00 p.m. and collation served.

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. Gerard R. Gessner, President, at 9:00 p.m. on April 16, at Roosevelt Hospital, Metuchen.

Dr. Robert Zullo, the secretary, read the minutes of the March meeting. These were accepted as read.

Dr. B. F. Slobodien, Chairman of the Judicial-Medical Ethics Committee, reported on approved applications which were presented for vote to membership. Applications accepted were for:

To Regular membership from Associate: Dr. William Pollen, Perth Amboy. To Associate membership: Dr. Man Wah Cheung, Metuchen.

Dr. Calvin, Chairman of the Constitution and By-Laws Committee, conducted the major part of the meeting which discussed the revision of the Constitution and By-Laws. Many corrections were made and the final version was accepted after a motion to that effect was carried. The final document will be submitted for legal advice. This will be printed in its final form and presented.

Dr. Gessner reported on the meeting in Trenton concerning the Forand Bill. Active opposition to this bill was urged in accordance with the A.M.A. stand. Letters of opposition should be sent to the individual members of the Ways and Means Committee. Dr. Calvin suggested that the names of the Ways and Means Committee members be sent to our members with request for each member to write a letter to the Ways and Means Committee members expressing their individual opinion concerning this Forand Bill. The Secretary of the Society was instructed to send a formal letter of opposition to each individual member of the Ways and Means Committee, telling them of this Society's stand in opposing the Forand Bill.

Dr. Clarke made a motion, which was accepted, that condolences be sent to Dr. Carlyle Morris' widow. Dr. Morris was an active member of the Society and one of our recent ex-presidents. His recent death was a shock to all. Dr. Gessner then appointed Drs. Clarke, Slobodien, N. N. Forney, Jr. and Witmer as a committee to draw up resolutions expressing condolences.

Dr. Zullo commented on the fact that plaques of appreciation be given to each outgoing president at the completion of his term. Dr. Gurshman made a motion that a "plaque" be given to each living ex-president and that a list be published in the Bulletin. This plaque was thought to be a fitting expression of gratitude on the part of the members of this Society toward their presidents.

Dr. Joseph F. Sandella, Chairman of the 1958 Nominating Committee reported on the panel of officers for 1958-1959.

The meeting was then adjourned and collation served.

R. G. MATFLERD, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held March 18, 1958 at the City Club in Passaic. Dr. Samuel C. Yachnin, the President, called the meeting to order.

The Secretary read the names of applicants for membership, and the following physicians were elected: Active members—Drs. Murray Nussbaum of Paterson and Irwin L. Maskin of Fair Lawn; Associate members—Drs. Louis Bertolotti and Chester J. Szmal of Clifton.

Dr. Yachnin reported on the Annual Press Dinner-Meeting held for three main newspapers in this area, members of the Welfare Council and Public Relations Committee. This was a very successful and satisfactory public relations project.

The President stated that a number of physicians feel there are certain inadequacies with regard to Blue Shield fees. We had received a resolution on this from the Hudson County Medical Society. The Passaic County Medical Society wished to present a somewhat different resolution. He then read the proposed resolution.

Dr. Yachnin also read the resolution presented by the Hudson County Medical Society. It was thereupon voted that we support the Hudson County resolution.

The President then turned the meeting over to Dr. Vito A. Lamberto, who said that this meeting was in memory of a young surgeon and member of our Society, the late Dr. Ernest E. Johnson, who died April 11, 1957. He was on the Surgical Staff of the Passaic General Hospital.

Dr. Lamberto then called upon Dr. F. Albert Graeter, who introduced the Co-chairman of the program, Dr. Bernard D. Pinck.

The latter physician introduced the guest speaker, J. William Hinton, M.D., Professor of Surgery, New York University Post Graduate School of Medicine. Dr. Hinton's subject was "The Diagnosis and Management of Acute and Chronic Pancreatitis." A question period ensued.

A sumptuous collation was then served by the Passaic City Club staff, with the Passaic General Hospital as hosts.

The regular meeting of the *Passaic County Medical Society* was held April 15 at the Medical Society Building. Dr. Samuel C. Yachnin, the President, presided.

The President called upon Chief Warrant Officer Emil Simonetti who made an appeal for nine medical officers to fill openings with the National Guard, and told the members about the opportunities in an army reserve hospital, especially for young doctors. He said that the local unit is one of the few surgical hospitals in the National Guard of the United States.

The following physicians were elected to membership: Active Members—Drs. Umberto Giannini, Passaic; Otto Eisert and Paul Stinlauf, Paterson; Associate Member—Dr. James W. Murphy, Pompton Plains; Courtesy Member—Dr. Peter A. Tucci, Paterson.

In the absence of the Secretary, Dr. Yachnin read a resolution on the death of Dr. Richard J. McDonald. The resolution was adopted as read.

The President informed the members that the Blue Cross rates will be increased in July of this year, and bills for the increase will be mailed to all those members covered by hospitalization in our group.

The question of endorsement of an Act passed by the Legislature of the State of New Jersey, requiring all children entering school to be vaccinated against polio, was thoroughly discussed. After considering various viewpoints, the following resolution was adopted:

Whereas, vaccination for protection against poliomyelitis has proved to be safe and effe tive;

Whereas, the Legislature of the State of New Jersey has passed an act which has been signed by the Governor, granting each school district the authority to require that all children entering school be vaccinated against polio;

Be It Resolved, that The Passaic County Medical Society endorses the purposes of this Act and urges that all school districts in Passaic County take steps to activate such a vaccination program.

The meeting was then turned over to Dr. Henry D. Shapiro who introduced the guest speaker, Robert C. Austrian, M.D., Professor of Medicine at State University, New York School of Medicine, Attending Physician, Kings County Hospital. Dr. Austrian's topic was "General Considerations in Antibiotic Therapy." A question period followed.

At the conclusion of the talk, a collation was served.

DAVID B. LEVINE, M.D.

Reporter

Salem

The Elmer Community Hospital was host to the regular monthly meeting of the *Salem County Medical Society* on Friday afternoon, March 21, 1958. Many of the doctors in the Society were still without electrical power or telephone service at their homes or offices at the time, but the hospital's emergency power supply was in operation and it was able to accommodate the visiting group as well as carrying on its usual functions. Dr. Donald H. Foster, president of the Elmer Community Hospital staff, conducted the Society members on a tour of the hospital plant, assisted by Drs. Muse A. Sheppard and Dorson S. Mills. The hospital served dinner.

A short business meeting was conducted by Dr. W. Garrett Hume; the nominating committee presented its candidates for officers of the Salem County Medical Society for the year 1958-59.

Officers for the coming year were elected at the regular meeting of the *Salem County Medical Society* on April 18 at the Du Pont-Penns Grove Country Club. New officers are: *President,* Dr. Charles E. Gilpatrick, Carney's Point; *Vice-President,* Dr. George A. Nitshe, Monroeville; *Secretary,* Dr. William L. Sprout, Salem; *Treasurer,* Dr. Donald A. McLean, Salem; and *Reporter,* Dr. George F. Reichwein, Central Park. Delegates to The Medical Society of New Jersey will be Drs. R. Louis Silverman and C. Spencer Davison with Drs. John S. Madara and Harry W. Fullerton, Jr., as alternates. Installation will occur at the Society's annual dinner at the Salem Country Club on May 24. The society observed with deep regret the death of Dr. Albert B. Kump of Bridgeton and resolved to send a message and floral tribute.

Drs. Reichwein, Charles B. Norton and Harry F. Suter were appointed to a special committee to plan a public education program explaining the society's views on such subjects as the use of antibiotic drugs and the need for everyone's prophylactic immunization against tetanus (lockjaw). The society passed a resolution endorsing the action of the staff of the Salem County Memorial Hospital to restrict voluntarily the use of two antibiotic drugs, both in the hospital and in their office practices, to infections proved to be caused by a staphylococcus organism resistant to all other drugs.

W. L. SPROUT, M.D.,

Reporter

Union

The annual meeting of the *Union County Medical Society* was held on April 9, at White Laboratories in Kenilworth. The society's members were guests of White Laboratories at a delicious roast beef dinner.

The business meeting began at 8:30 p.m. with Dr. Thomas S. P. Fitch presiding. Mr. H. C. Lundquist, personnel director of White Laboratories welcomed the physicians gathered.

Ovid Santoro and Gerald V. Schoenbrun of Plainfield were elected to Associate membership. Herbert Poch and Alvin Schwartz of Elizabeth were elected to Active membership. Frederick Rayl of Cranford was received as a transfer from Windham County Medical Society of Connecticut.

The following officers were elected for the ensuing year:

President—Graham C. Newbury, Summit; President-Elect—Nathan S. Deutsch, Plainfield: First Vice-President—Carl G. Kapp, Elizabeth; Second Vice-President—Henry J. Konzelmann, Hillside; Secretary—Charles W. Boozan, Elizabeth; Treasurer—Henri E. Abel, Elizabeth; Reporter—Elbert H. Pogue, Elizabeth.

Dr. Graham C. Newbury, the new president, resides in Summit and maintains offices in Summit and Cranford. He is a general surgeon and is director of surgery at the Overlook Hospital.

The feature of the evening was the president's address, delivered by Dr. Fitch. Dr. Fitch reviewed the events of the past year and thanked the various committees and officers for their service and cooperation.

On behalf of the society, Dr. Newbury presented Dr. Fitch with a plaque as a testimonial in recogntion of his faithful service.

The meeting was adjourned at 9:45 p.m.

ELBERT H. POGUE, M.D.

Reporter

Mrs. A. Guy Campo: Auxiliary Leader



THE JOURNAL gives a special tip of the hat to Helen Campo. Printing and typesetting are among her hobbies. Also boating and fishing. She was born Helen Turini in 1917—in Allegheny County, Pennsylvania. Her family, reversing the traditional travel trend, moved east, and Helen became a student nurse at the Sacred Heart Hospital in Allentown. The Commonwealth of Pennsylvania gave her her R.N. in 1936. Nurse Turini then moved to Pennsylvania's big city where she was placed in charge of the admitting office at the Graduate Hospital. Then and there came one A. Guy Campo, M.D., Result: wedding bells.

In 1939 Mrs. Campo joined the Woman's Auxiliary to the Gloucester County Medical Society. It took her all of two years to become president of that Auxiliary. In 1952, the Auxiliary demanded an encore and she was president again. Mrs. Campo, between presidencies, served in various committee capacities, first for the county auxiliary, later for the Auxiliary to The Medical Society of New Jersey.

Mrs. Campo finds time to be active in the Westville Women's Club, in the Rotary Anns, in the PTA, in the auxiliary to several south Jersey hospitals, in her church and so forth. And so forth. She also has three children, Anne Alberta, Anthony Guy, junior and Mary Elizabeth—ages 17, 13 and 1 respectively.

In her spare time (did any one ask, what spare time?) she summers at Ocean City and indulges in four hobbies listed on top of the page.

Chewing Power, Limited

Very little chewing is required for maximum digestion, Dr. John H. Farrell reported in the *British Dental Journal* (100:149, 1956). "A person having a masticatory efficiency of 23 per cent can masticate well enough to digest any of the foods tested," he said. Hundreds of experiments were carried out to determine whether mastication is necessary for complete utilization of food. Of the 29 foods tested, 18 left large undigested residues if they were not chewed. These included pork, bacon, beef, mutton, lamb, chicken, potatoes, peas and carrots. The other 11 foods, including cod, beef fat, kippers, eggs, rice, white and whole-wheat bread, and cheese, were digested easily whether chewed or not.

The effects of varying efficiencies of mastication also were investigated. In a patient with partial upper and lower dentures, for example, their removal resulted in a marked fall in masticatory efficiency but did not affect the subject's ability to digest the given foods.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Introduction to Anesthesia. By R. D. Dripps, M.D., Leroy Vandam, M.D. and J. E. Eckenhoff, M.D. Pp. 266. Philadelphia, 1957. Saunders. ($4.75)

Practicality is the keynote of this little manual. Essentially a procedural guide rather than a philosophic treatise, this text emphasizes the "how-to-do-it" aspect of its subject. It includes practical pointers on record keeping, pre-anesthetic rounds, taking blood pressure, making death reports, and teaching residents: all this in addition to the standard instructions on technic. There is a chapter on narcotic poisoning, another on muscle relaxants. Other off-trail topics included here are anesthetist-surgeon relationships, infant resuscitation, the lay-out of a recovery room, and the architecture of an anesthetic machine. All together a wonderful anesthesiologist's *vade mecum*, especially precious to the occasional anesthesiologist—but not beneath the dignity of the experienced anesthesiologist either.

VICTOR HUBERMAN, M.D.

Ulcerative Colitis. By Harry E. Bacon, M.D. Philadelphia, 1958. Lippincott. Pp. 395. 184 Illustrations. ($15.00)

This book fills a gap in the library of the gastrointestinal internist. Dr. Bacon has done an excellent job in compiling the literature on ulcerative colitis and has added the results of his own extensive experience. He discusses the various concepts of etiology with stress on emotional factors. His discussion of treatment is based not only on the reports of other investigators but also draws excellent and positive conclusions from his own experience. He states that 60 per cent of the patients can be treated conservatively. Here he includes psychiatric, general and dietary measures together with a description of the large number and variety of available drugs. The complications of ulcerative colitis are described in detail and that of pregnancy and its management in the different phases of the disease is particularly helpful. There is a worthwhile section on the manifestations of the disease in children. All of the facets are made more vivid and understandable by the fine selection of case reports.

Half of this volume is devoted to the surgical aspects of the disease. One can, in this chapter, detect the real reason for writing the book—a plea for earlier and more radical surgery with the resultant restoration of a severely chronically ill and debilitated patient to a useful member of society, normal in all respects save for the permanent ileostomy. He advocates total colectomy in the majority of cases requiring surgery. Pre-operative and postoperative care both immediate and in the follow-up with the fitting of an ileostomy bag, are fully described.

The book is a timely one. It is of value primarily to the gastrointestinal internist, to the pediatrician and to the surgeon. The general practitioner too will benefit greatly by reading it.

SYDNEY ROSENTHAL, M.D.

Clinical Heart Disease. By Samuel A. Levine, M.D. Philadelphia, 1958. Saunders. Pp. 673. Ed. 5. ($9.50)

This book is more a compendium of Dr. Levine's clinical approach to heart disease than an up-to-date review of cardiology. It is written in an easy-to-read personal style (the use of the first person pronoun is a departure not usually found in texts), and the most valuable nuggets are the descriptions of Dr. Levine's own methods of handling cardiac problems.

The text begins with rheumatic fever, reflecting the genesis of this book in Boston, where the disease is so prevalent. The subject is covered admirably, with emphasis on the atypical forms of rheumatic fever. The author underscores the significance of minimal symptoms such as repeated nosebleeds in children or unexplained repeated vomiting. Rheumatic pancarditis is considered, followed by a discussion of each of the valvular deformities. Next there is a chapter devoted to the pericarditides followed by space for angina pectoris and coronary thrombosis. (The use of this archaic term instead of myocardial infarction troubled this reviewer.)

In discussing the latter, Dr. Levine displays enthusiasm for the bedside method of treatment, presenting physiologic and clinical data to support this. Incidentally, Dr. Levine is also an advocate of routine anticoagulant therapy for all patients with proved myocardial infarction.

Space is devoted to unusual aspects of heart disease, such as rare forms of cardiac disorders. There is brief mention of epilepsy in the differential diagnosis of Adams-Stokes syncope. There are also

chapters on the medicolegal aspects of heart disease and the systolic murmur.

Dr. Alexander Nadas, Cardiologist of the Children's Hospital, Boston, has written a fine chapter on congenital heart disease, and Dr. Harold D. Levine wrote the chapter on clinical electrocardiography, a 231 page text in itself.

Dr. Levine's volume is excellent from the clinical point of view. However, there are no diagrams, plates or other forms of illustrative material for the first 404 pages, when the final chapter on electrocardiography begins. Nor are there chapters on modern diagnostic methods used in cardiology, such as radiology, fluoroscopy, cardiac catheterization or radioactive isotope studies. There is no discussion of rehabilitation of the cardiac patient, a most important facet of practice today.

The general physician who wishes a readable, comprehensive book on clinical cardiology will find this one of value. Serious students of heart disease will gain little from it, other than the pleasure of discovering Dr. Levine's own approach to their day-to-day problems.

R. D. Goodman, M.D.

Endocrine Pathology of the Ovary. By John M. Morris, M.D. and Robert E. Scully, M.D. St. Louis, 1958. Mosby. Pp. 151. ($8.50)

The study of endocrinopathies of the ovary has progressed greatly during the past few decades. Drs. Morris and Scully describe the development of the follicles and their striking changes in appearance during their life span. They give detailed definition and picture of Exner bodies. They demonstrate that the theca-lutein cells and the stromal cells resemble Leydig and adrenal cortex cells. The embryology of the gonads is correlated to functioning ovarian tumors which may reproduce morphologic stages of the embryonic phases of the gonads.

Hermaphroditism and pseudohermaphroditism are masterfully differentiated. The authors emphasize that the masculinization and feminization are not exclusively due to the hormones of the testes and ovaries; "the adrenal gland is the major, if not the sole source of extragonadal sex hormones" and some steroid hormones "may have varying degrees of bisexual effect." Feminizing tumors arising from testis elements are fully described. Urinary level values of female and male hormones in physiopathologic conditions have been given. "The new-born infant has a high extrogen level which is placental and maternal in origin." Estrinism, defeminization and masculinization are concisely outlined. The presentation of single follicle cyst, policystic ovaries with estrinism or with the Stein-Leventhal syndrome is of medical and surgical interest. The outline given about individuals showing "complete feminization but with undescended testes in place of ovaries" deserves special mention.

The book contains a large and well selected collection of pictures. It, in a compact and clear form, familiarizes the clinician, the gynecologist and the pathologist with the physio-pathology of the ovary. While progress in endocrinology is far from complete, the present knowledge of clinical physiology and pathology of the ovary has been well condensed in this book making the physician "richer in ideas and in the understanding of the present limits of our knowledge."

William Forte, M.D.

Epilepsy. Letitia Fairfield, M.D. Pp. 159. New York, 1957, Philosophical Library. ($4.75)

Intended for epileptics and their friends, this slim manual gives a lot of practical information on the management of epileptics, their potentialities for work, marriage, and future health. It is a British publication so that some of the information on health insurance, automobile licensing and the like is not applicable to American practice. There is a handy question-and-answer catechism in the back and a very brief glossary in the front. The lack of an index makes it hard to look up an item in a hurry. The book includes a discussion of first aid for epileptics, the work of the British Epilepsy Association and the pros and cons of colony living for epileptics. The intelligent epileptic will find this a thought-provoking book.

Herbert Boehm, M.D.

Human Biochemistry. I. S. Kleiner, Ph.D. and James M. Orten, Ph.D. St. Louis 1958. Mosby. Ed. 5. Pp. 808. ($9.00)

The wheel of medicine has turned again and we are once more in an era of chemistry. Chemotherapy in general medicine, chemical explanations of mental illness, electrolytic imbalance in surgery, ACTH in rheumatism, coal tar and cancer, are samples of the problems which have made biochemistry once more a necessary substrate to clinical medicine. Although neither of these authors is a physician, their book is clinically oriented. The chapter on physical chemistry is hard sledding for the clinician (at least it was for this one) and I am not sure that the mathematics of the Henderson-Hasselbach equation has any place in a book for students and practitioners. But apart from these minor defects, this is a solid if unexciting text of physiologic chemistry. The authors cover energy metabolism, the chemistry of the body fluids(blood, milk, hormones), the biochemistry of foods, the nuclear chemistry of cells, as well as the classical rubrics of physiologic chemistry. They

include a unique chapter on chemical structure in relation to biologic phenomena, and some new material on the chemistry of antibiotics. The book contains 52 useful tables, 100 figures (5 of them in color) and countless structural formulae. Four previous editions of this book have given substantial service to medical and dental students, and this new edition should be even more useful.

Ulysses M. Frank, M.D.

The Relation of Psychiatry to Pharmacology. By Abram Wikler, M.D. Baltimore 1958. Williams and Wilkins Company. Pp. 322. Paper. ($4)

The American Society for Pharmacology and Experimental Therapeutics has sponsored and subsidized this textbook of psychopharmacology. It covers the effects of drugs on human behavior—drugs such as carbon dioxide, barbiturates, LSD, mescaline, alcohol and reserpine, and so on down the spectrum. The book is exceedingly heavy in style—you can read 2 or 3 pages without even a paragraph break. One paragraph (beginning on page 231) is 6½ pages long! Dr. Wikler covers the theories of drug action and discusses psychologic as well as physiologic effects of behavior-modifying drugs. This is a solid if unexciting basic book for all interested in psychopharmacology.

Abraham Leff, M.D.

Fat Consumption and Coronary Disease. T. L. Cleave, M.D. New York, 1958. The Philosophical Library. Pp. 38. ($2.50)

Cleave argues that coronary disease is related to *unnatural* fat consumption. Man can absolutely rely on his unmodified appetite to lead him to a healthy diet. When he has to eat processed foods, or foods which someone else selects for him, then his appetite is no longer a reliable guide. Craving for sweets may make ice cream appetizing, but then the eater is getting a lot of fat he did not crave. There are actually only 31 pages of text in this booklet which sells at $2.50.

Peter O. Garner, M.D.

Diabetes as a Way of Life. By T. S. Danowski, M.D. New York, 1958. Coward-McCann, Inc. Pp. 177. ($3.50)

Presentation of medical subjects to the laity is an art which few have mastered. If the author is a doctor, he frequently gets involved in medical terminology hardly understandable to the layman. If the author is a layman he will often subconsciously distort the facts in order to simplify the subject. It is therefore refreshing to come across a book by a medical authority who writes in a style appealing and understandable to the general public. Dr. Danowski's little book is a practical one. It discusses the history of diabetes, carbohydrate metabolism, insulin, diabetic diets, hypoglycemic agents, and all the major complications of diabetes plus sound medical advice on how to avoid them. A valuable question and answer chapter is included. What impressed me particularly was the emphasis which the author placed throughout the book on the long-range problem—how to adjust oneself to future life with diabetes.

This is a valuable guide to a new diabetic. It clarifies many problems which torment the mind of one who has just been told that he is diabetic. Additionally, a diabetic of long-standing may profit in many ways from suggestions made by the author. *Diabetes as a Way of Life* can be highly recommended to all diabetics. It will also prove very helpful to practicing physicians in instructing their patients.

Otto Brandman, M.D.

Hospital Accreditation References. Chicago 1958. American Hospital Association. Pp. 136. Paper. ($3.25)

The American hospital system is one of the strangest in the world. It is a 5-billion dollar enterprise, representing a network of buildings which serve as hotels for the sick (some of them veritable cities of the sick), workshops for physicians, community health centers, schools, and research installations. Control of this essentially medical operation has largely fallen into the hands of nonphysicians on governing bodies or in administrators' offices. Since the governing body has legal and moral responsibility for good hospital management, it has been necessary to establish increasingly complex standards. These are largely administered by the Joint Commission on Accreditation. This volume is a compilation of hospital standards, model by-laws for staffs and boards, and questions and answers about conformity to the standards. It covers every aspect of hospital operation from outpatient department to the medical library, from nursing to dentistry, from the governing body to the social service.

This book will at once assume its place as a bible for hospital administrators, and for physicians serving as hospital staff officers. It will also be a convenient reference work for any doctor who is interested in the way his own hospital meets the standards of the Joint Commission.

Henry A. Davidson, M.D.

TUBERCULOSIS Abstracts

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Vol. XXXI June, 1958 No. 6

The Surgical Treatment of Pulmonary Coccidioidomycosis with a Comprehensive Summary of the Complications Following this Type of Therapy

Dermont W. Melick, M.D., The American Review of Tuberculosis and Pulmonary Diseases, January 1958.

● Surgery has a definite place in the treatment of pulmonary coccidioidomycosis despite a complication rate of 13 per cent in the 400 cases studied. There is no good antifungal agent now available to assist in protecting the patient when surgery is performed.

Introduction. This is a report on 400 cases of coccidioidomycosis treated by surgery. Sixty-six different surgeons participated, including the writer.

The data for the most part were gathered by the questionnaire method. One such questionnaire was sent out in 1950 and a second in 1953. A questionnaire for 1957 is incomplete. Some of the 1957 data are, nevertheless, used in order to bring the report up to date.

Indications for Surgical Therapy. The indications for surgical therapy are presented in a somewhat arbitrary grouping, but it is hoped this will aid in clarification.

Absolute Indications—Group I

a. Giant Cavity (more than 5 cm.); b. Infected cavity; c. Ruptured cavity—giving rise to Bronchopleural fistula, Empyema, Nonexpansile lung, or Persistent pneumothorax.

Probable Indications—Group II

a. Enlarging cavity; b. Cavity with hemorrhage.

Possible Indications—Group III

a. Coin lesion; b. Persistent cavity; c. To establish diagnosis, 1. Tumefaction, 2. Other inflammatory lesions: tuberculosis, histoplasmosis, blastomycosis.

The absolute indications under Group I will cause very little comment, as the necessity for surgery is obvious.

The probable indications under Group II are those cases with definite warning signs of impending complications. Definitive surgical therapy is considered to be indicated. An enlarging cavity, particularly if it is near the visceral surface of the lung, may rupture. This not infrequently results in a pneumothorax. The more disturbing sequelae of rupture are bronchopleural fistula, empyema, and nonexpansile lung. Rarely a patient may be fortunate enough to have only a minimal pleural effusion following rupture. Intracavitary hemorrhage may be severe. Recurrent hemorrhage in a cavity usually demands surgical extirpation.

The possible indications (Group III) will not be universally accepted among thoracic surgeons. Most thoracic surgeons are inclined to the well-founded belief that all "coin lesions" demand early thoracotomy in order to establish the diagnosis with accuracy. Emphasis has been placed on the high percentage of malignancy (15 to 35 per cent) in the coin lesion.

The "coin lesion" due to coccidioidomycosis is a frequent finding in the endemic area. It is estimated that the "coin lesion" in the endemic area will be found to be malignant in less than 5 per cent of cases. The decision to be made by the individual surgeon in such an area is whether this reduction in percentage justifies conservatism.

It would appear, therefore, that the "coin lesion" in the endemic area should be given more scrutiny than the "coin lesion" in other geographic areas. This would imply a careful history of past febrile episodes, adequate skin testing

(with particular attention to the 1:100 to 1:10 coccidioidin), plus blood-agglutination and complement-fixation tests. It is believed by some that the roentgenographic appearance exhibits characteristics highly suggestive of coccidioidomycosis. The disease is not infrequently located near one of the pulmonary fissures and it has a propensity for burrowing across the fissure from one lobe to another. This "crossing the fissure" sign lends weight to a presumptive diagnosis of coccidioidomycosis. If, after careful search, the diagnosis of the "coin lesion" remains indeterminate, the decision for exploratory thoracotomy will not be questioned. Caution, however, should be exercised by the surgeon. In one report of resections for "coin lesions," the surgeon performed lobectomy in three of four cases. In order to prevent undue loss of lung tissue, a more localized excision may be advisable to establish the diagnosis.

The second possible indication is persistent cavitation. Depending on the size of the cavity, most physicians (and even some surgeons) would prefer to treat such a case conservatively. The cavity may disappear and surgery be unnecessary. Some California surgeons believe disappearance of a cavity is wishful thinking and that "recavitation" in the same area will occur sooner or later. One surgeon, however, found cavity closure to occur in 25 per cent of his first ninety-two patients. Cavitary lesions have been observed to remain the same size for months and even years. The present writer has observed one case of bilateral cavitation with gradual decrease in size of both cavities and eventual disappearance during a period of two and one-half years. If a cavity persists for twelve to eighteen months without closure and specifically if it is not definitely decreasing in size, the chances of its closing spontaneously are remote indeed. One should bear in mind that the complications reported in the latter part of this paper have been found to follow cavitary lesions much more frequently than to follow surgery or solid lesions. This may be explained by the fact that the mycelial form of Coccidioides immitis is present in 50 per cent of cavitary cases and in only 10 per cent of solid lesions.

Comprehensive Summary of the Complications Following Surgical Therapy. The complications following surgery for coccidioidomycosis are probably higher than might be surmised from reading the reports in the literature. A recent article states that complications were experienced in three of the seven patients operated upon.

The 400 cases herein reported have had a complication rate of 13 per cent (seven deaths occurred in this group.) One group of surgeons reported only five complications in 110 cases, while another in their 55 cases, reported five complications.

The complications range from persistent postoperative pneumothorax through empyema and nonexpansile lung to bronchopleural cutaneous fistula and multiple chest wall sinuses. In the 54 cases reported by the present writer, the ten complications can be divided into five major and five minor complications. The major complications were:

1. Bronchopleural cutaneous fistula with multiple chest wall sinuses.
2. Bronchopleural cutaneous fistula with empyema characterized by debilitation and invalidism of the patient.
3. Recurrence of cavity resulting in bronchopleural cutaneous fistula following secondary operation.
4. Bronchopleural fistula with empyema requiring open drainage and followed by a prolonged period of healing.
5. Persistent cavitation at the same site of removal of the original cavity.

The five minor complications included two cases of empyema treated successfully by repeated thoracentesis; one case of persistent minimal hemoptysis (present over a period of fifteen months) thought to be due to a small cavity in the same area at the original resection with eventual spontaneous closure of cavity and cessation of hemoptysis; progressive pneumonitis in the same area as the resection with evidence of a small cavity with eventual spontaneous resolution and cavity closure; and one case of persistent pneumothorax followed resection.

The over-all complication rate of 13 per cent may be expected to continue as long as the etiologic agent is not controlled by any of the known antimicrobial drugs. Despite the complications, there is no doubt that surgery has a definite place in the treatment of pulmonary coccidioidomycosis.

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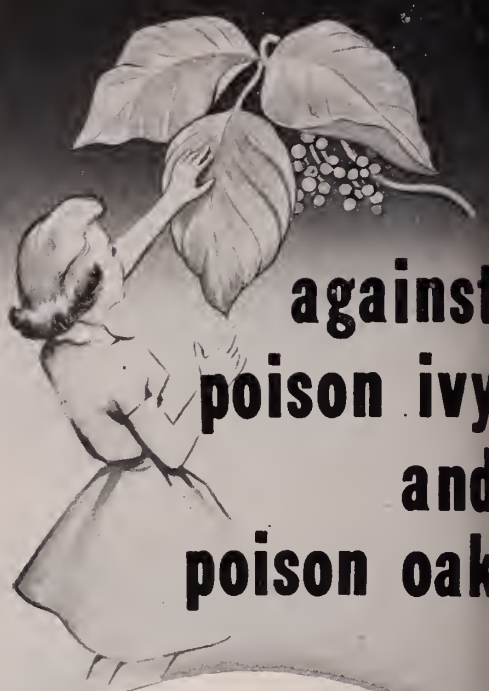
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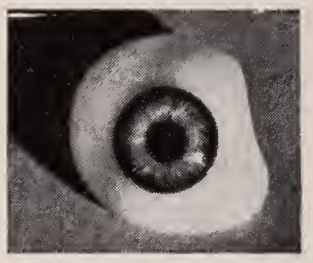
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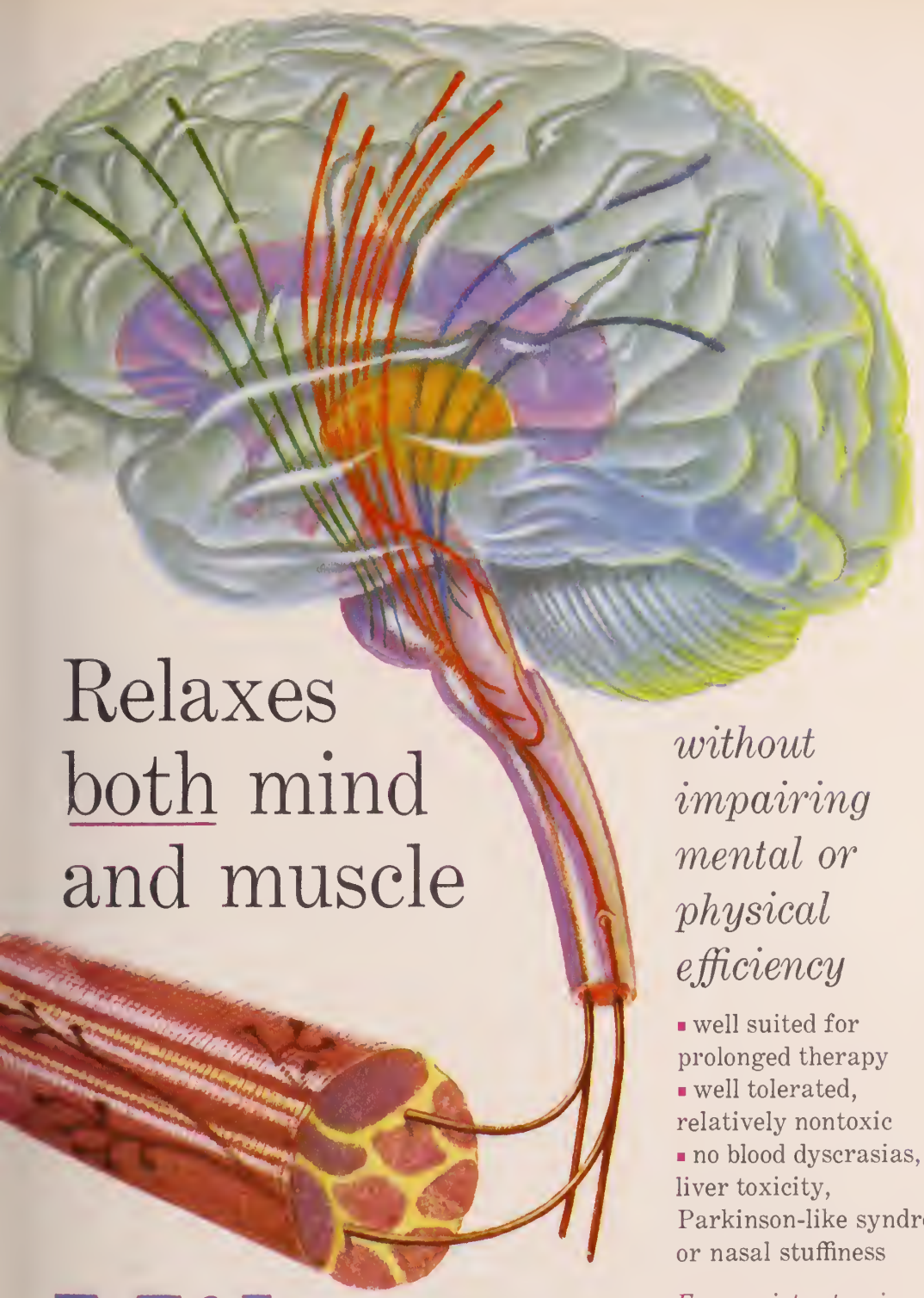
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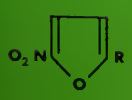
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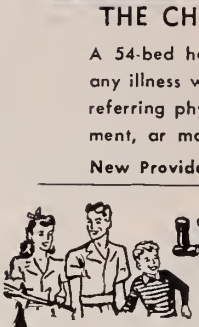
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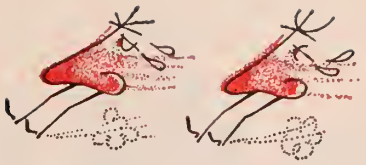
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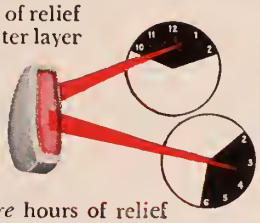
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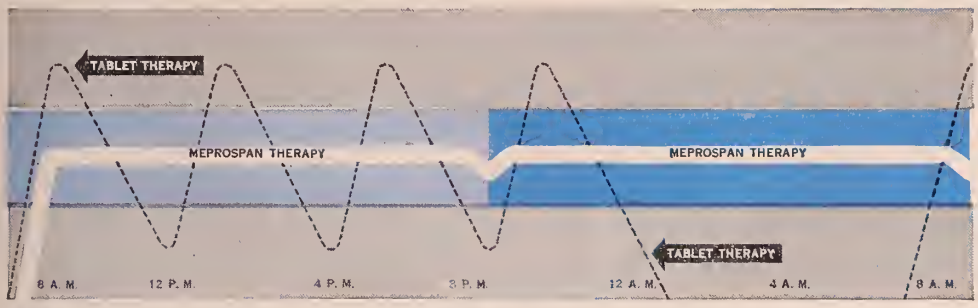
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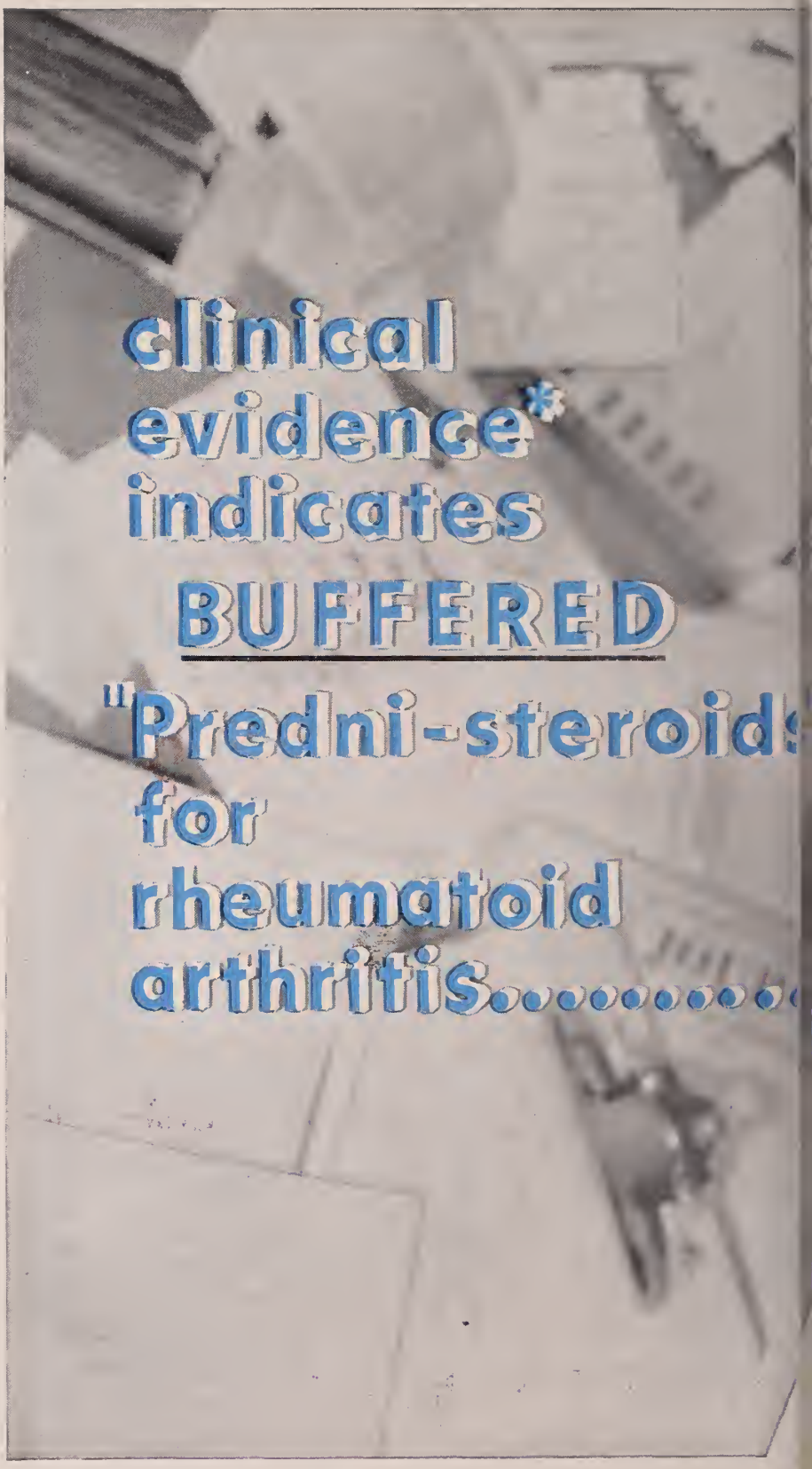
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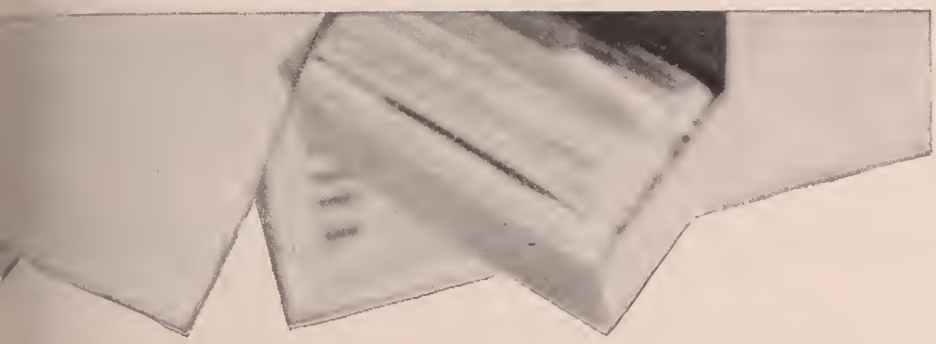
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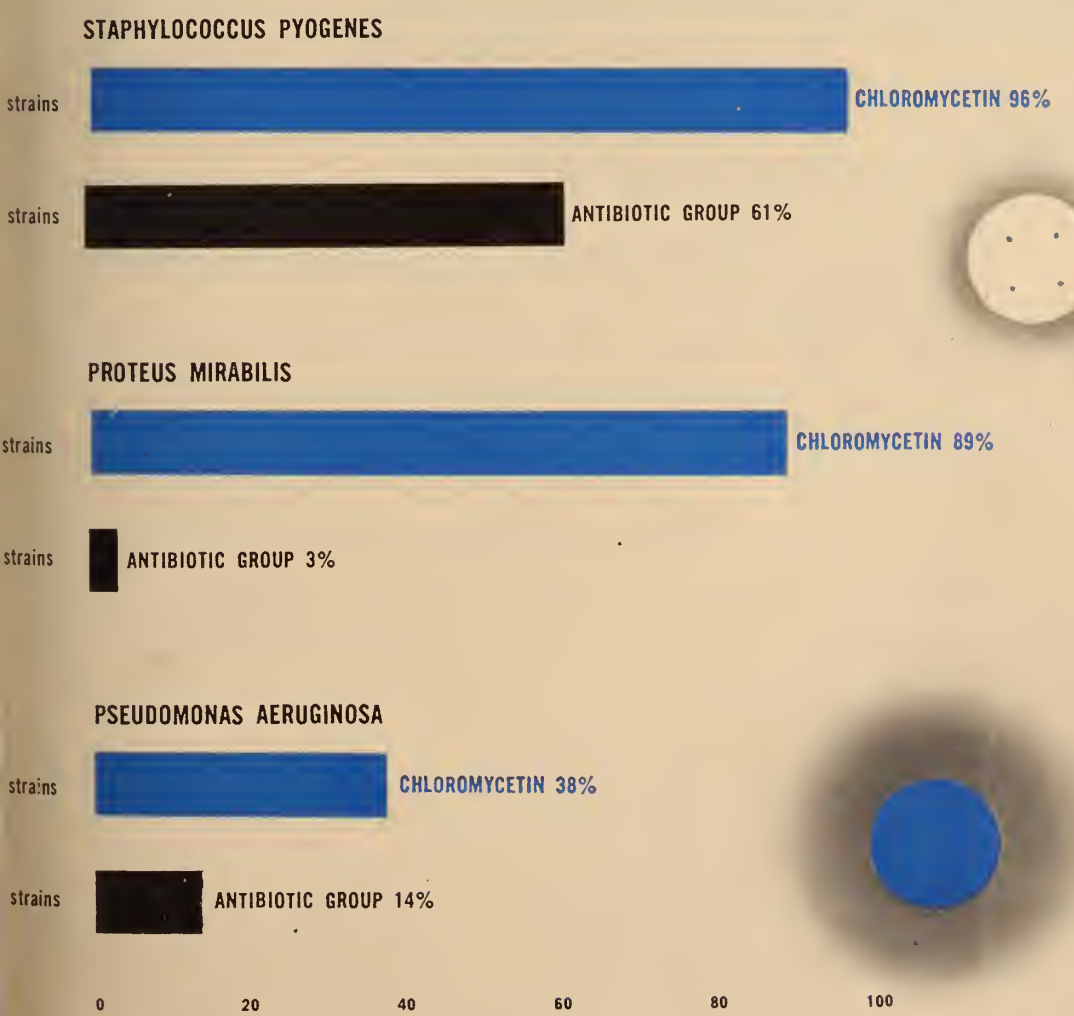


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WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812

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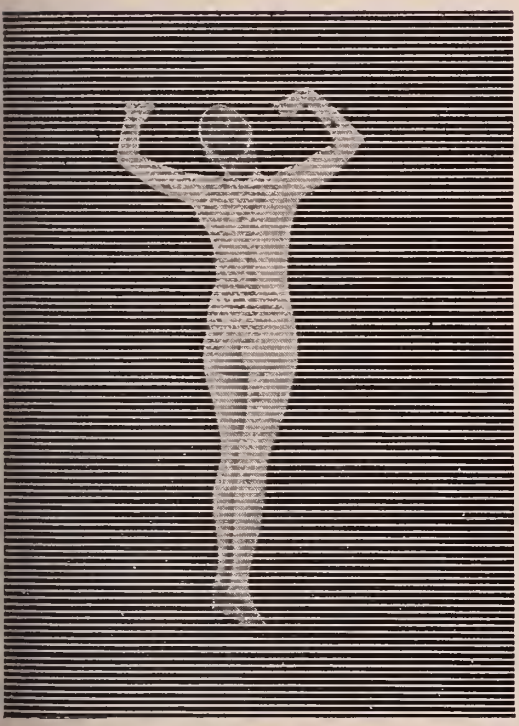
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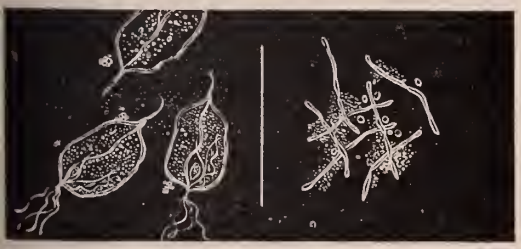
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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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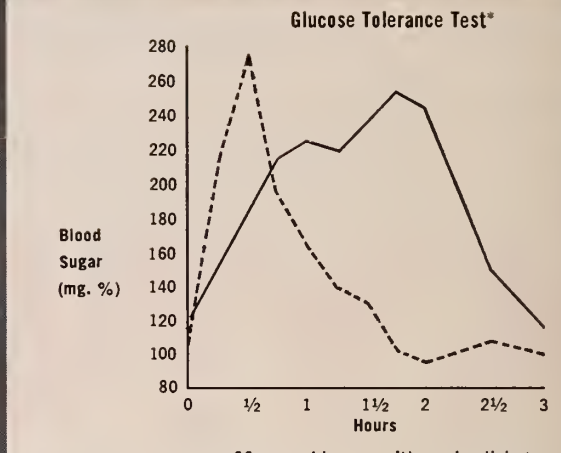
references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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REFERENCES: 1. Flippin, H. F.: Virginia M. Month. 82:435, 1955. 2. Caswell, H. T., et al.: Surg. Gyn. Obst. 106:1, 1958. 3. Nesbitt, R. E. L., Jr., and Young, J. E.: Obst. Gyn., N. Y. 10:89. 1957.

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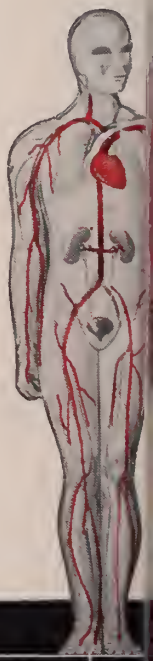
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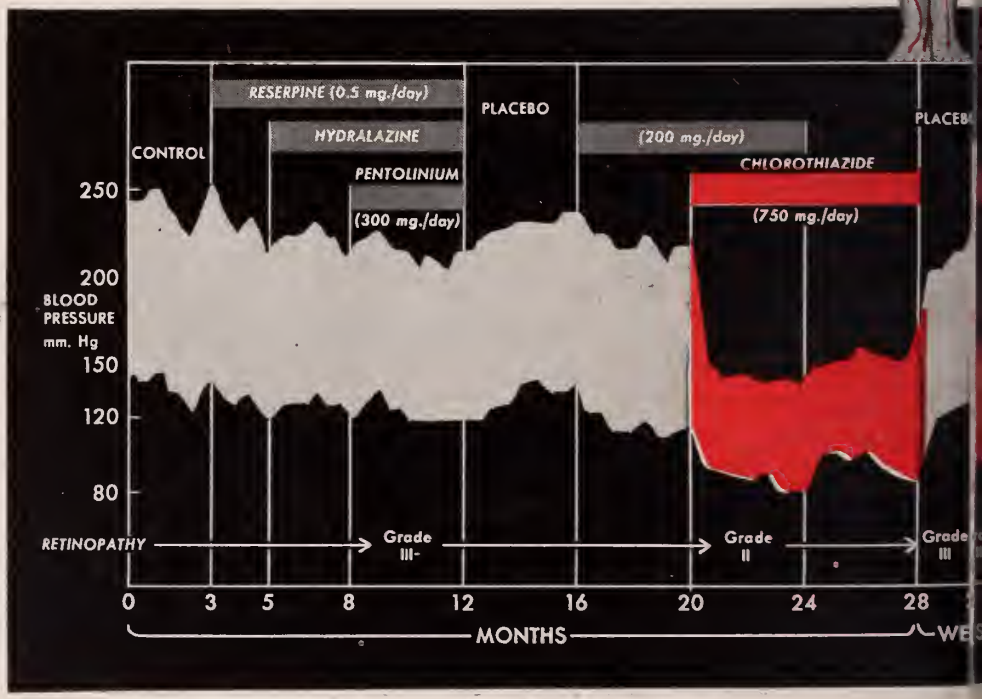
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, Septe

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2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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Recovery from severe infectious processes entails more than emergence from the effects of the causative agent. The semistarvation, the inactivity, the suppression of physiologic activity must all be corrected as rapidly and thoroughly as can be tolerated by the patient.

Return to normal nutrition can be speeded by an easily digested diet high in top quality protein and vitamin-mineral components.

Lean meat serves several purposes in such a program: It supplies easily digested protein of highest biologic quality for rapid re-establishment of nitrogen balance; it provides the gamut of B vitamins as well as certain minerals important to sound nutrition, and it brings appetite-stimulating flavor to meals, a consideration not to be underestimated in the psychic rehabilitation of appetite.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

If Monilial overgrowth is a factor

Achrostatin* V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

Combines ACHROMYCIN V with NYSTATIN

SUPPLIED:

CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

ACHROSTATIN V combines ACHROMYCIN† V ... the new rapid-acting oral form of ACHROMYCIN† Tetracycline ... noted for its outstanding effectiveness against more than 50 different infections ... and NYSTATIN ... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

*Trademark †Reg. U. S. Pat. Off.

Lederle

for adults and children



Prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
Exempt Narcotic. Available on Prescription Only.

Winthrop LABORATORIES
New York 18, N. Y.





little

How to win friends ...

The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).



We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.

Mazola® Corn Oil...a palatable food effective in the management and contr of serum cholesterol levels

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal . . . high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cook oil as well as a delicious salad Adequate amounts can be eaten daily in a wide variety of salad dressings a in a great number of fried and bal foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Maz Corn Oil is stable and dependable, p viding the full measure of cholester lowering unsaturated fatty acids ch acteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery sto throughout the country, is availa everywhere. Its comparatively low c makes it as economical as it is effecti

CORN PRODUCTS
REFINING COMPANY



MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.



EW—

NTROLS

PRESSION

THOUT STIMULATION

Relieves depression without masking it with artificial elation ▪ Restores natural sleep without depression-producing aftereffects ▪ Reduces depressive rumination ▪ Often makes electroshock therapy unnecessary ▪ Deprol acts promptly and has a simple dosage schedule. *No known liver toxicity. No effect on blood pressure, appetite. No effect on sexual function.*



Deprol†

Side effects are minimal and easily controlled by dosage adjustment. Does not interfere with other drug therapy.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Recommended Starting Dose: 1 tablet q.i.d

Reference: *Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A.* 166:101 *March 1, 1958.*

Literature and samples on reques

WALLACE LABORATORIES
New Brunswick, N. J.

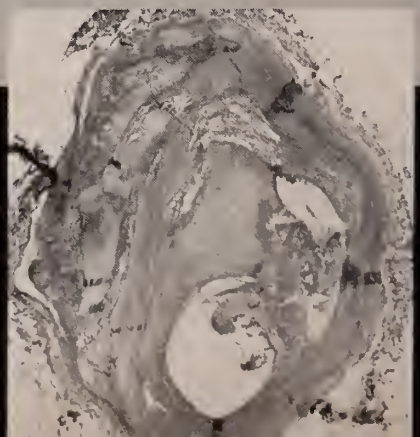
†TRADE-MARK

split-level therapy

in the control of **hypercholesterolemia** and **atherosclerosis**

1. the dietetic level — unsaturated fatty acids (safflower oil) act to counterbalance ingested saturated fatty acids . . . which helps shift atherogenic beta-lipoproteins to the more normal alpha-lipoproteins . . . and reduce elevated cholesterol levels.*

2. the physiological level — lipotropic factors stabilize function of the liver . . . the site of metabolism of cholesterol, lipoproteins and other lipids.



Lufa

APSULES

original anti-atherosclerotic formula combining lipotropic factors with unsaturated fatty acids... in convenient form... about 3¾ calories per capsule.

Each LUFA capsule provides:	
UNSATURATED FATTY ACIDS**	378 mg.
PYRIDOXINE HCl (B_6)	2 mg.
CHOLINE BITARTRATE	233 mg.
dl, METHIONINE	110 mg.
INOSITOL	40 mg.
DESICCATED LIVER	87 mg.
VITAMIN B_{12}	1 mcg.
VITAMIN E (dl, alpha-tocopheryl acetate)	3.5 I.U.

**from specially refined safflower seed oil. Provides approximately 294 mg. of linoleic acid.

dosage: Therapeutic, 6 to 9 capsules daily, in divided doses. Maintenance, one capsule b.i.d. or t.i.d.

supplied: Bottles of 100, 500 and 1000 capsules.

ecial diet sheets for patient distribution and LUFA samples and literature on request.

s. vitamin corporation • PHARMACEUTICALS

ington-Funk Laboratories, division)



MENNEN BABY MAGIC
Actually prevents
and heals diaper rash!

A THREE-HANDED ASSISTANT...



MENNEN BABY OIL
A better, safer cleanser
than soap!

IN THE FIGHT AGAINST DIAPER RASH!



MENNEN BABY POWDER
It's wet-resistant; protects
babies better against
diaper rash, chafing!

MENNEN... Baby Specialist since 1880

in each of these indications for a tranquilizer...



SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.



Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.



Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.



Senile anxiety and persecution complex dogged Mrs. K. until her doctor prescribed ATARAX Syrup. (+) It tastes good, and it's a perfect vehicle for Mrs. K's tonic.

Dosage: Children, 1-2 *10 mg.* tablets or 1-2 tsp. Syrup t.i.d. Adults, one *25 mg.* tablet or 1 tbsp. Syrup q.i.d.

Supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

...ATARAX® gives you an extra benefit

(BRAND OF HYDROXYZINE)

ROERIG Rx

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

NOW... an advanced ACTH

SIGNIFICANTLY IMPROVED

CORTROPHIN®-ZINC

(Corticotropin-Alpha Zinc Hydroxide)

A unique electrolytic process* of manufacture gives a fine, easily resuspended aqueous suspension of Cortrophin-Zinc with these therapeutic advantages:

★ **VIRTUALLY PAINLESS** . . Unsurpassed patient acceptance.

★ **HIGH PURITY** . . . . . Virtually pure ACTH with fewer mg. of foreign protein per injection.

★ **RAPID ACTION** . . . . . New form stimulates peak adrenal output within two hours.

★ **LONG ACTION** . . . . . Provides ACTH activity for several days.

★ **ECONOMICAL** . . . . . Lower total ACTH dosage and fewer injections required.

Cortrophin-Zinc is indicated in the treatment of more than 100 diseases, including rheumatoid arthritis, bronchial asthma, allergies and hypersensitivities, bursitis, serum sickness, conjunctivitis and other eye diseases, ulcerative colitis, atopic dermatitis and other skin diseases.

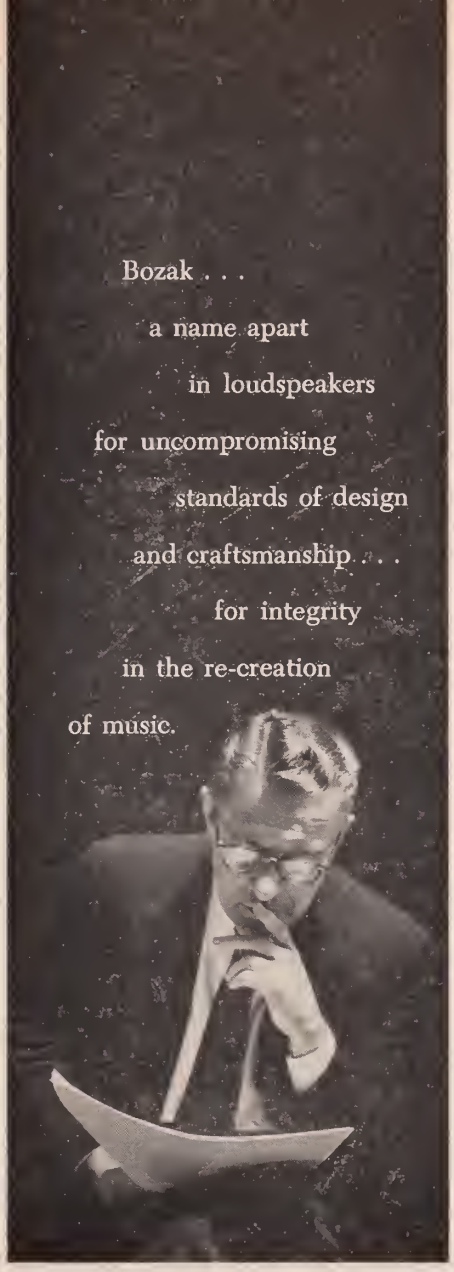
★ Ask your Organon representative or write for clinical and experimental reports substantiating these claims.

SUPPLIED: 5-cc vials containing 40 and 20 U.S.P. units of corticotropin per cc; 1-cc ampuls containing 40 and 20 U.S.P. units of corticotropin, with sterile disposable syringes.

Pat. Pending
Available in other countries as Cortrophine-Z.

Organon inc. ORANGE, N. J.

Bozak . . .
a name apart
in loudspeakers
for uncompromising
standards of design
and craftsmanship . . .
for integrity
in the re-creation
of music.





Hear the Bozaks at a franchised Bozak dealer/write for literature
The R. T. Bozak Sales Co/Box N/Darien, Conn.

in cases of tension

Serpate®

(Reserpine, Vale)

. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedation without hypnosis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies

RAUWOLFIA
SERPENTINA

in cases of hypertension

Rauval®

(Rauwolfia Serpentina, Vale)

. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content
tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

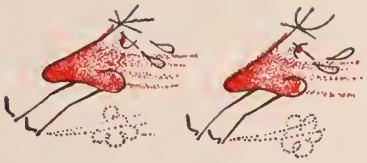
. . . achieves gradual lowering of the blood pressure, gentle sedation, tranquilization with prolonged effect even after cessation of therapy

supplied: 50 mg. and 100 mg. tablets in bottles of 100 and 1000, or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*
PHARMACEUTICALS



running noses . . .



and other hay fever symptoms

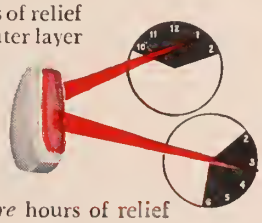
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

*Trademark

TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

Triaminic®

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

probably the easiest-to-use x-ray table in its field



Instant swing-through from fluoroscopy to radiography (and vice versa). Self-guiding to correct operating distance. Nothing to match up . . . you do it without leaving the table front.



Horizontal, vertical, intermediate, or Trendelenburg positions by equipoise handrack (or quiet motor-drive).



Choice of rotating or stationary anode x-ray tubes. Full powered 100 ma at 100 KVP.

certainly the simplest automatic x-ray control ever devised



know why? *look* . . .

1 On this board you select the bodypart you want to x-ray

2 Set its measured thickness

3 Press the exposure button

That's all there is to it. No time, KV, or MA adjusting to do. No charts to check, no calculations to make.



housed in this handsome upright cabinet

obviously as canny an x-ray investment as you can make

Modest cost
Excellent value
Prestige "look"
Top Reputation (significantly, "Century" trade-in value has long been highest in its field)

And you can rent if you prefer.

Call in your Picker representative (he's probably in your local 'phone book) or write: PICKER X-RAY CORPORATION 25 South Broadway, White Plains, N. Y.

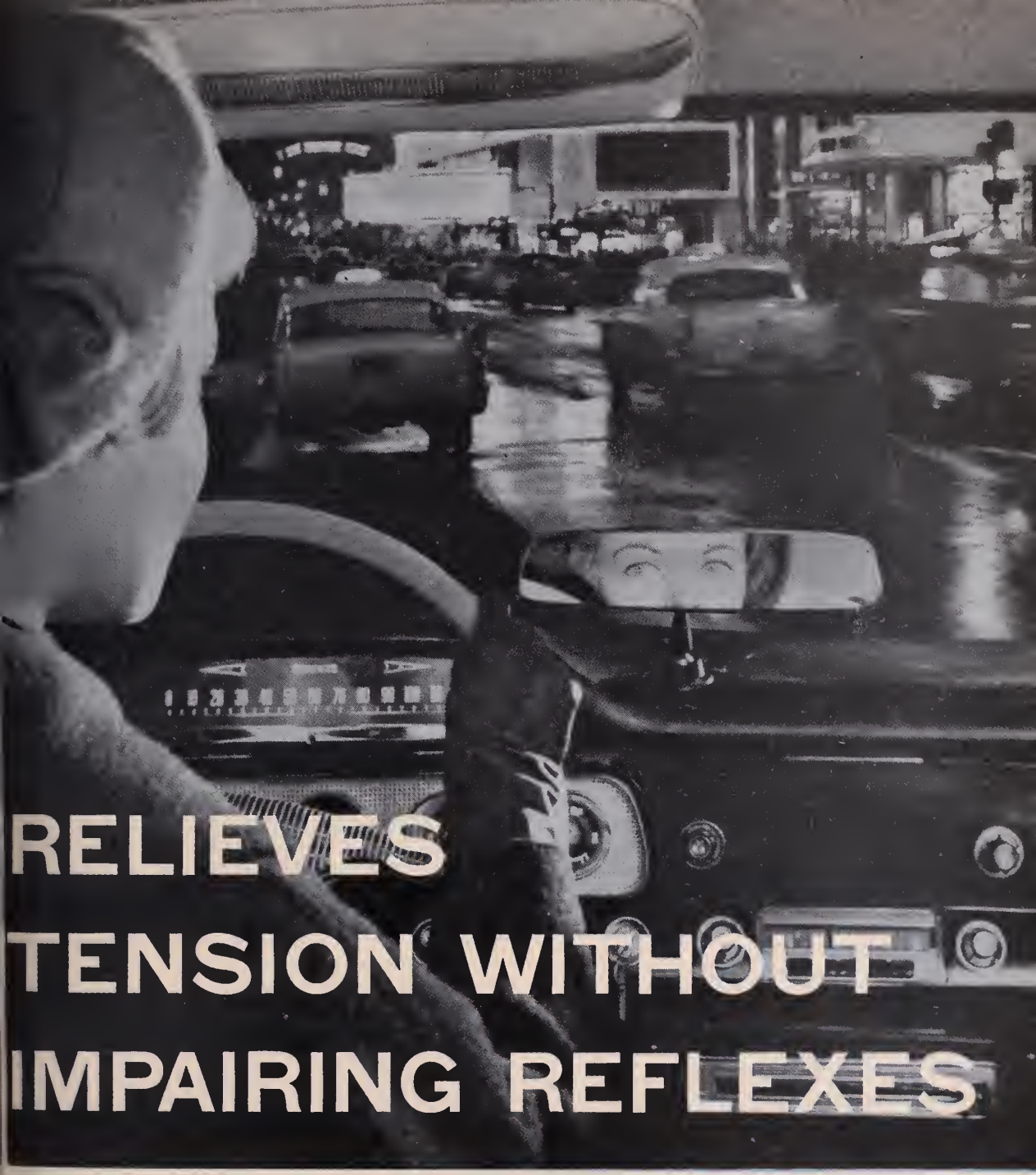
anatomatic Century
diagnostic x-ray unit

Picker



NEWARK 2, N. J., 972 Broad Street
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Arlington, N. J., 186 Belleville Pike

Matawan, N. J., 52 Edgemere Drive
Philadelphia 4, Pa., 103 S. 34th S
(Southern N. J



RELIEVES TENSION WITHOUT IMPAIRING REFLEXES

Even in double the usual dosage,
[Miltown] produces no behavioral toxicity
in our subjects as measured by our
tests of driving, steadiness, and vision."*

Relieves anxiety, tension and muscle spasm in everyday practice

- with unexcelled safety
- without impairing autonomic function

Miltown®
meprobamate (Wallace)

Usual Dosage:
One or two
400 mg. tablets t.i.d.

Supplied:
400 mg.
scored tablets,
200 mg.
sugar-coated
tablets,
bottles of 50.

*Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

CM-7261

"WHO, ME, DOCTOR?



I haven't eaten a square meal in months!"

Rabudex-G.R.

CAPSULES

Will help manage:

- The "Nibbler"
- The "Compulsive Eater"
- The "Patient who slyly slips on the pounds"

by

Supplying the more effective 3 to 1 ratio of Dextra to Levo Amphetamine as suggested by Freed and Mizel. (1)

Providing a mild sedative to control nervousness and anxiety (2) often found in obese patients.

RABUDEX—G.R. capsules are released over a period of 8 to 10 hours with approximately one-third the total dose released in 15-20 minutes and the remaining two-thirds released gradually over the next 8 to 10 hours. As the effects may last as long as 12 hours, RABUDEX—G.R. should be given early in the day.

Each RABUDEX—G.R. Capsule contains 22.5 mg. dextra amphetamine — 7.5 mg. leva amphetamine plus Butabarbitol Sodium 45 mg. as provided by:

Dextra Amphetamine Sulfate ---------- 15 mg.
Racemic Amphetamine Sulfate ---------- 15 mg.
Butabarbitol Sodium -- 45 mg.

LYNN PHARMACAL COMPANY CAMDEN, N. J.

Available In Bottles Of 100 - 500 - 1,000 Capsules
Sample Supply On Request

REFERENCES

1. Freed, S. C., and Mizel, M.: Annals of Int. Med., June, 1952.
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15), 1949.

LYNN PHARMACAL COMPANY — CAMDEN, NEW JERSEY

MY DAD— HE HURT HIS BACK REAL BAD



"It happened at work while he was putting oil in something"

"He told Mom his shoulder felt like it was on fire"

"He couldn't swing a bat without hurting"

"But Doctor gave him some nice pills--and the pain went away fast"

"Dad said we'd play ball again tomorrow when he comes home"

AND THE PAIN WENT AWAY FAST

FOR PAIN

Percodan®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC) **TABLETS**

ACTS FASTER...
usually within 5-15 minutes

LASTS LONGER...
usually for 6 hours or more

MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

RARELY CONSTIPATES...
excellent for chronic or bedridden patients

and now... **NEW**

Percodan®-Demi

VERSATILE

New "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,628,185

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.

For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



with new

CARTRAX*

PETN + ATARAX®

(PENTAERYTHRITOL TETRANITRATE) (BRAND OF HYDROXYZINE)

why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

Rx PFIZER

NEW YORK 17, NEW YORK
Division, Chas. Pfizer & Co., Inc.

*Trademark

WEBCOR

SENSATIONAL MONEY SAVING OFFER!

LIMITED TIME ONLY!

BASIC
HI-FI RECORD
ALBUM LIBRARY

Retail Value 39.80

FREE

with your choice of any
1958 "MAGIC MIND"
WEBCOR

High Fidelity
CONSOLE FONOGRAF



Prelude. High fidelity with "Magic Mind" Diskchanger. 4 speeds. One 6" x 9" woofer, two 4" tweeters. Powerful amplifier. Automatic shut-off. Mahogany. *Limed Oak or Cherry Wood* $179.95 **$169.95**
Also available with superheterodyne AM radio tuner.

FREE

WEBCOR Factory Service and WEBCOR Replacement Parts at Webcor Authorized Service Depots thruout Factory Warranty Period!

Available at all **Dept. Stores and Better Music, Record, Camera and Appliance Dealers.** Write for catalog to Exclusive N. J. Wholesale Distributors
ALL-STATE DISTRIBUTORS, INC., 457 Chancellor Ave., Newark, N. J.



"Since we've had him on NEOHYDRIN he can walk without dyspnea. I wouldn't have believed it possible a month ago."

oral
organomercurial
diuretic

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN

LAKESIDE

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1, 2, 3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

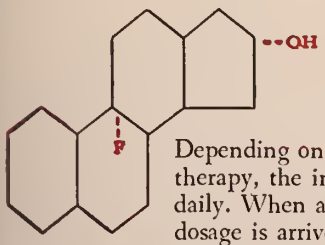
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3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
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10. Barach, A. L.: Personal Communication.
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13. Dubois, E. L.: Personal Communication.

ocort®

Triamcinolone LEDERLE

...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

when you treat hypertensive patients

double duty RAUDIXIN

Squibb Standardized Whole Root Rauwolfia Serpentina

is the solid base line for successful therapy



Raudixin helps you relieve pressures in your patients

Raudixin "lowers blood pressure and slows the pulse rate much more efficiently than the barbiturates. . . . It is not habit-forming and is synergistic with all other known hypotensive drugs."*

Raudixin helps you relieve pressures on your patients

Raudixin "relieves anxiety and tension, particularly the tension headache of the mild hypertensive patient, better than any other drug."*

RAUDIXIN..."is the best symptom reliever."*

In mild to moderate cases, Raudixin is frequently sufficient.

Base line therapy with Raudixin permits lower dosage of more toxic agents. The incidence and side effects of these agents are minimized. Diuretics often potentiate the antihypertensive effect of Raudixin.

*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

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1. Thomas, J. W.: Ann. Allergy *16*:128, 1958

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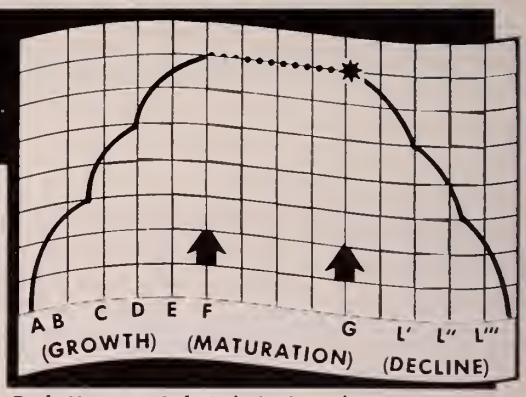
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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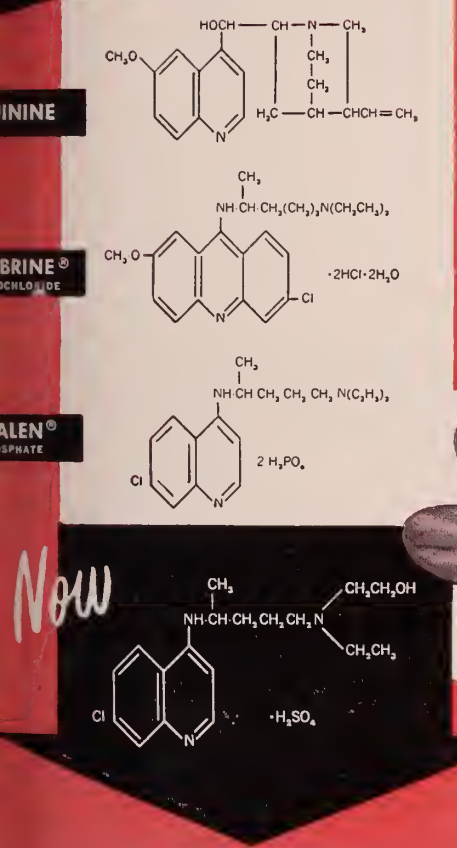
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Editorials • • •

Sticking Your Neck Out

According to C. J. Stetler* (and he ought to know) one out of every four California physicians has been served papers as a defendant in a malpractice action. Mr. Stetler expects this trend to move east. "The vast majority of these claims," says Mr. Stetler, "are not justly founded. In some localities the likelihood of being sued is becoming so great that it constitutes a definite occupational hazard. And the majority of all professional liability claims and suits filed involves physicians who are above the average of their respective groups in skill, experience and professional standing.

"Approximately 18,500 living physicians in the United States have had a claim or suit brought against them at some time . . . " However, "40 per cent of these claims and suits have been dropped or decided in favor of the physician."

"If the present trend continues," Mr. Stetler warned, "and if a physician must become increasingly apprehensive of legal suits, his own defensive instinct will inevitably, in some measure, overcome his humanitarian and professional motivations. Such a doctor will be inclined to give too much time to protecting himself and less to the care of his patient. He may hesitate to assume responsibility in a case where the prognosis is poor. He will have a tendency to omit the highly successful, but slightly dangerous, medical procedures."

Mr. Stetler puts his finger on one of the more important and more subtle untoward effects of malpractice litigation. Suppose, for example, you are 99 per cent sure that this is a benign condition. Still, they might sue you, alleging negligence if you omitted even a single laboratory study or failed to summon a consultant. So, you say "why stick my neck out?"

*Mr. Stetler is director of the Legal Department of the American Medical Association. These remarks come from a talk delivered by Mr. Stetler before the Medical Council of the Washington Metropolitan Area sponsored March 27, 1958 by the Wm. S. Merrell Company.

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Accordingly you order more and more laboratory work, summon a whole corps of consultants, keep the patient longer in the hospital. Nobody is going to say *you* were negligent. This over-cautiousness leads to higher bills for the patient, and this in turn causes more complaints about the high cost of medical care. It also has the effect of forcing physicians to adhere to tried methods of treatment—even if they don't work—rather than use potent newer drugs or procedures which might backfire. No progress would ever be made in medicine if some doctors and some patients had not agreed to stick their collective necks out.

Physicians are unwilling to testify that brother practitioners have been negligent. This does not seem to have hurt plaintiffs any — judging by the size and frequency of verdicts. The reluctance of doctors to brand their brethren as negligent has been the subject of recent criticism by plaintiffs' attorneys. They allege that this reluctance is a conspiracy to protect the incompetent. The truth is, however, that a rash of malpractice litigation does *not* serve the public interest. For the reasons just indicated, trigger-happy plaintiffs are, in the long run, going to lower standards of public health. A certain amount of boldness, with the full understanding of the patient, is an essential part of successful medical care.

Doctor's Dilemma

One of the potential poisons in the doctor-patient relationship, is the possible compensation angle or "excuse from work" angle that may develop out of any visit to the office in this insurance-centered culture. Most skilled workers belong to unions that provide benefits while the member is unable to work . . but they also demand doctors' certificates supporting such a claim. A physician's letter may influence a Veterans Administration Regional Office to upgrade a rating. Between commercial companies and Blue Shield, half of the population have health insurance coverage where certification of illness makes a tremendous difference to a patient.

This puts the private practitioner on the horns of a dilemma. Many cases are "borderline" enough to give any honest doctor some leeway. If he tries to be tough, he antagonizes his patient. If he is a quick man with a certificate, he suspects he is being played for a sucker. Who can say how painful, how disabling a backache is? When does a sore throat warrant an excuse from work?

Behind this is the major philosophical question of tomorrow's medicine. For whom is the doctor working? The patient—in the sense that he is aiming at the patient's welfare. But if the company pays, the doctor has an obligation to the company too. And what happens when it is to the patient's interest to emphasize the disability and to the company's interest to make light of it?

Under the traditional "adversary" system what happens is that eventually a claim is litigated, and the two doctors take the stand, subject themselves to cross examination, and—presumably—truth is hammered out. The jury the judge, or the referee, as the case may be weighs each doctor's appearance, learning, testimony, the sensibleness of his view and his response to cross examination—and then decides whose testimony should have more weight. However as insurance spreads, decisions will more often be made administratively, with less use of the courts. Cross-examination will become less of a factor and the doctor's report more important. Which will complete the cycle and resharpen the doctor's dilemma.

Robert J. Ryan, M.D.*

Trenton

Antibiotics and Wound Strength

Although given with the best of intentions, penicillin and tetracycline appear to impede wound healing. This interesting and novel experiment demonstrates that wounds heal better without antibiotics.

The effects of antibiotics on the host are of prime consideration. Penicillin has its bactericidal effect by interfering with the normal synthesis of bacterial protein. The assimilation of preformed glutamic acid is decreased and the dissimilation of cellular ribonucleic acid in bacteria is specifically inhibited.[1] Tetracycline groups also may interfere with bacterial synthesis of protein or they may alter cellular oxidative metabolism.[1]

I have noticed that wounds of patients receiving antibiotics prophylactically in "clean" cases had a higher incidence of skin and fascial dehiscence. To substantiate this impression, an experiment was devised with rats to check objectively the effect on host wound healing by antibiotics.

METHODS AND MATERIALS

Thirty rats, female, four to five weeks of age of the Wistar strain, *Mus norvegicus albinus* were used. A long left paramedian muscle splitting incision was made from the left subcostal margin to the anterior aspect of the pelvis, under open drop ether anesthesia. The peritoneum was opened and then the abdominal wall was closed with through-and-through figure-of-eight number 35 steel wire. One group of ten rats acted as the controls, and received no antibiotic as is advised for clean wounds.[2-7] Another ten received 5000 units of crystalline penicillin intramuscularly daily. A third group received 17 milligrams of crystalline tetracycline intramuscularly daily.

All were placed on a high protein, vitamin supplemented diet with water. The food analysis showed 23 per cent crude protein with B_{12}, riboflavin, thiamin, niacin, and A vitamins together with brewer's yeast.

The rats were sacrificed on the eighth postoperative day, and their wounds were checked for tensile strength.

RESULTS

All the control group of rats lived and flourished. Of the penicillin group that received 5000 units per 80 Grams of body weight (equal to adult human dose of about 4.5 million units daily), only one died and it bit its wound open and eviscerated. Of the tetracycline group that received 17 milligrams per 80 Grams body weight (equal to adult human dose of about 15 Grams daily), eight died. Autopsy revealed an absence of perforated bowel or peritonitis. The lethal dose for rats has not been worked out, but for mice, the toxic dose[3] intramuscularly is 500 to 1000 milligrams per kilogram or 60 milligrams per 80 Grams (far more than the dose we employed). The intramuscular route of crystalline tetracycline yields blood serum levels for about eight hours.[4] Chlortetracycline has been shown[5] to injure the liver with fat

*Chief Resident in Surgery, St. Francis Hospital, Trenton, New Jersey. This work is from the Department of Pathology, St. Francis Hospital, Trenton, New Jersey.

accumulation and vacuolization in the central portions of the hepatic lobules.

The ventral abdominal walls were excised after the rats were brought to medullary arrest with chloroform. Thereafter, the wire sutures were removed and a squared-off portion of the abdominal wall, measuring 15 millimeters across the wound which bisected the portion, was taken. The suture line was placed on graduated tension by fixing it on one side with fishhooks tied to a ring-stand and applying weights to a bag attached by fishhooks to the opposite side of the wound. The weights were just sufficient to cause separation of the suture line.

In the control group, the weight of the rat at the end of the experiment averaged 109 Grams; the "pull" to the suture line averaged 549 Grams. In the penicillin group the figures were 105 Grams for weight and 466 for "pull." In the tetracycline animals the figures were 86 and 473 Grams respectively. In other words, the control group had the strongest wounds by an average of 80 Grams of "pull."

COMMENT

ANTIBIOTICS, at least in part, have the lethal effect by interfering with protein synthesis. The bacteria no longer utilized glutamic acid, and possibly ribonucleic acid normally.[1]

In wound healing, the stage of fibroplasia follows the initial or lag phase. This is after the sixth day and because of fibroplasia, a wound assumes increasing tensile strength.[6] In the process of fibroplasia, the fibroblasts lay down collagen, a protein, as fibrils. The new fibrils then fuse with those of the periphery as do the proliferating cellular elements. Epithelization may proceed from the edges, followed by the third stage of scar retraction.

This experiment has indicated that *the tensile strength of the wounds of rats receiving penicillin and tetracycline was less than that of wounds in rats receiving no antibiotics.*

There may be a connection between the impaired protein synthesis of bacteria and the fibroplasia of animals both receiving antibiotics.

CONCLUSIONS

1. The control group of albino Wistar female rats which received no antibiotics had the strongest laparotomy wounds.

2. This study lends another argument against prophylactic use of antibiotics in clean wounds, because it indicates that the antibiotics, penicillin and tetracycline, impede wound healing.

Acknowledgment is made to Robert Keene, M.D., and to Raymond Kostrewa, M.D., who gave anesthesia.

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Ralph Hall, M.D.

Westfield

Don't Use Phenolated Medications on Poison Ivy!

It is a temptation to prescribe a phenolated lotion for poison ivy. Phenol does relieve itching. It is antiseptic and anesthetic, too. But, as Dr. Hall here points out, this may be compounding a trauma.

Poison ivy dermatitis can be aggravated by applying a phenolated or carbolized lotion such as phenolated calamine.* There is a temptation to use a phenol preparation because of that drug's well known anti-pruritic, antiseptic and anesthetic properties. However, ivy poisoning (including such variants as sumac and poison oak) is due to a fixed nonvolatile oil called toxicodendrol which has phenolic groups. The poison is identical or very similar in all three plants. A standard dermatology text discusses it as a vesicant oil on the same page as mustard gas.

Toxicodendrol has phenolic groups as the active principle. The blisters of the dermatitis may be likened to blisters of a second degree burn.

Consider now the popular phenolated calamine.* Phenol is a benzol derivative soluble in fats and oils and on local contact, it coagulates proteins. In short its characteristics are similar to toxicodendrol in chemistry and actions.

Applying phenol on top of toxicodendrol is applying a phenol on top of a phenolic group. Clinically this is verified by the observation that phenol applied to small vesicles quickly converts them into coalescing bullae. On the basis of logic and observation, carbolized calamine lotion is contra-indicated in ivy poisoning and patients should be so warned. Other chemicals used as anti-pruritics which also coagulate proteins to a greater or lesser extent include oxyquinoline, crotonatoluide, and certain salicylates.

The lesion of poison ivy is a second degree chemical burn on top of a hive. The serum from the blister is like the serum from any blister. Once the injury has been established, several positive statements can be made: Poison ivy dermatitis—

1. Is not contagious
2. Will not spread. It only *appears* to spread as more dermatitis comes out on contiguous areas as the lighter infections take effect.
3. Is not adversely affected by water.

Adequate treatment, aside from prophylaxis, is one of the anti-allergic medications as long as the hives persist, plus soaks in unmedicated hot water. One soaking in hot water for ten minutes gives relief from itching for three to four hours.

*Calamine lotion is a mixture of zinc oxide, glycerine, calcium hydroxide, ferric oxide, and a variety of clay known as "bentonite." The addition of 1 per cent phenol makes this a phenolated calamine.

547 East Broad Street

Martin H. Wortzel, M.D.

Thomas C. Rommer, M.D.

Newark

Erysipelas-like Lesions of the Lower Extremities

With modern potent drugs, the cure is sometimes worse than the disease. Here, for instance, penicillin, used to control secondary infections, produced a marked reaction. Fortunately, this responded dramatically to steroid therapy.

Erysipelas-like lesions on the lower extremities have long been known as a complication of dermatophytosis of the feet. McGlasson,[1] who was the first to report it, concluded that the lesions were areas of cellulitis or erysipelas caused by[2] "lymphatic transmission of bacteria which had invaded the legs through fissures and erosions of fungus origin that were situated between the toes." Therefore, the fungi appeared to act as[2] "passive bystanders serving as the causal role of opening the portals for bacterial penetration into deeper tissue and lymphatic channels." This concept was supported by the fact that adequate treatment of a focus of dermatophytosis of the feet prevented, in many instances, recurrence of the erysipelatous eruption of the legs.

Sulzberger[3] was the first to suggest that the erysipelas-like eruption of the legs might represent a complication of fungus hypersensitivity. He concluded that an allergic response rather than the direct bacterial infection produced the eruption. His evidence favored interpreting the eruption as dermatophytids; but he could not deny the possibility that some of these erysipelas-like eruptions might be caused by cocci. If so, they would be true erysipelas lesions. Sulzberger[3] could not rule out the probability that some might be caused by a combination of fungus hypersensitivity and direct bacterial invasion.

Since the publication of these two conflicting views, there have been many papers[4,5,6,7] either agreeing with or challenging the concept of the allergic response to fungus infections of the feet causing these erysipelas-like eruptions of the legs.

Eruptions of erysipelas-like lesions on the legs have been a comparatively rare manifestation in everyday dermatologic practice. One of us (MHW) has compiled a list of four private patients with this eruption seen between 1949 and 1954. During the past three years, however, we have suddenly seen a tremendous increase in these patients and we have

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now amassed a file of eighteen eruptions of erysipelas-like lesions of the lower extremities. They have presented a rather uniform history.

The purpose of this communication is to report the sudden increased incidence of the allergic manifestation of the erysipelas-like lesions. The history and course of all these patients were so uniform that we are reporting in detail only one typical case.

REPORT OF A CASE

A 52-year old woman had been bothered by recurring fungus infections of both feet for the past three years. She had always been able to control the fungus infection with one of the commercial undecylenic acid preparations that she bought in a drugstore. However, two weeks before this hospital admission, she found that this preparation seemed for the first time to make her "athlete's foot" worse. After having used it for 7 consecutive nights, she noted a marked swelling and pain of her big toes. She saw little "water blisters" over the top and bottom of each foot (Dermatitis venenata?). She went to her family physician who confirmed the diagnosis of tinea pedis and told her that she had a secondary irritation and infection of her feet. He continued the commercial preparation and gave her repeated daily injections of penicillin. The eruption got worse. Her feet swelled and became more painful. Three days after the institution of penicillin therapy, her physician placed her on potassium permanganate soaks and another commercial antifungal preparation. He gave her oral penicillin, one tablet of 200,000 units three times daily. The patient, in her zeal, doubled the concentration of the potassium permanganate soaks. Instead of using them twice daily as directed she used them four to six times daily. Three days after this continued therapy she was completely bedridden. Her legs had become so swollen and painful that she could not use them. She then noted for the first time that the eruption had spread to her legs. She developed two large, red, elevated lesions that seemed to encircle both legs three inches above her ankles. Having seen erysipelas as a child, she thought that this was erysipelas and became alarmed. At this stage, she was immediately hospitalized and was seen in consultation the following morning.

Examination: The patient appeared moderately ill but had no fever. Over the lower two-thirds of each leg were large, dull-hued, diffuse, erythematous plaques, each 8 to 12 centimeters in width. They completely encircled each leg. They had irregular, festooned outlines. The border of the affected area was elevated and the surface was a livid red. The lesion was tender and was hot to the touch. There was no evidence of phlebitis, lymphangitis, nor inguinal lymphadenopathy. She had a moderate scaling and vesicular dermatophytosis of both feet. There was marked maceration and scaling of the fourth and fifth interspaces of the toes. The ventral and dorsal surface of the anterior third of each foot was markedly swollen and the site of an acute erythematous, vesicular, dermatitis venenata. There was an acute paronychium of each large toe. The white blood count was slightly elevated and the differential count showed a slight shift to the left. Serologic test for syphilis was nonreactive. There was adequate arterial circulation of each leg and there was no clinical nor laboratory evidence of gout nor other acute manifestation of one of the arthritides. It was our impression that this patient had indeed had a fungus infection of her feet that had been greatly stimulated by the penicillin. She also had a superimposed contact dermatitis from the local applications that she had applied.

Fungus culture revealed Trichophyton gypsium. Bacterial cultures of her feet showed various staphylococci and nonhemolytic streptococci. A culture from the erysipelatous lesion was negative for fungi and for bacteria.

Course: She was placed on local boric acid compresses. Because we thought that these erysipelas-like lesions were due to bacterial invasion, the patient was placed on tetracycline (250 milligrams four times daily). She was re-examined in 72 hours. The contact dermatitis of her feet had markedly improved. However, the erysipelas-like lesions of her legs were still at the same stage as on our initial examination, though they appeared a little more tawny. We now felt that they were allergic manifestations, either to her original fungus infection or to contact irritation. Accordingly, she was placed on prednisolone in addition to the tetracycline. She was given 40 milligrams of prednisolone daily for the next 48 hours.

Results were astonishing. In two days, the lesions of her legs had almost completely disappeared. The only residuum was a slight erythematous tinge and some scaling. The vesiculation had completely disappeared, the temperature of the area was that of a normal skin, and the patient was ready and willing to get out of bed. The tetracycline was discontinued and she was maintained on slowly lowered dosages of prednisolone. Her course was uneventful and she was discharged from the hospital to be followed as an out patient eight days after her admission. The tinea pedis subsequently cleared with soothing antifungal applications.

We have concurred with Sulzberger and his group [3] that among the inflammatory lesions of the lower extremities complicating dermatophytosis of the feet the incidence of erysipelas-like Id is low compared with that of eruption caused by cocci. "Lesions on the lower extremities caused by streptococci emanating from foci of dermatophytosis include cellulitis, lymphangitis, superficial phlebitis, and erysipelas—the incidence is in the order mentioned.

An erysipelas streptococcid may also occur from an allergic response to the bacterial products themselves."

The factors which condition a peculiar allergic predisposition of one well defined, localized area of skin are imperfectly understood. This was a relatively rare manifestation until recently. The patient described above was only one example of 14 that we have seen during the past three years. The widespread use of penicillin has caused exacerbations of (pedal) fungus infections. This has been reported many times. The incidence of erysipelas-like lesions of the lower extremities seems to have paralleled the increased use of penicillin. Most practitioners, however, have mistakenly felt that the erysipelatous manifestation is itself a primary infection and, therefore, have continued penicillin only to exacerbate the eruption. All 14 of our patients responded dramatically to steroid therapy. This supports Sulzberger's findings [3] that many of these eruptions are only manifestations of a dermatophytid.

We have been able to see clinically and to follow in most of our patients the events leading to the development of an acute erysipelas-like eruption of one or both of the lower extremities. The eruption always cleared dramatically to the anti-allergic and anti-inflammatory action of internal steroid therapy.

SUMMARY

We are reporting a rare eruption that has increased markedly in incidence during the past three years.These are not primary infections of the skin itself. They respond dramatically to steroid therapy. They probably are the result of penicillin therapy used to control the secondary infection so frequently present with a fungus infection of the feet. However, this plus a strenuous local external regime have increased the skin's sensitivity to the primary tinea and have caused these erysipelas-like eruptions. The basic fungus infection must be eradicated with suitable, soothing, local, antifungal measures after the acute erysipelas-like Id reaction has been cleared.

31 Lincoln Park (MHW)

375 Osborne Terrace (TCR)

Hebrew Medical Journal Celebrates Thirtieth Anniversary

The Hebrew Medical Journal, under the editorship of Moses Einhorn, M.D., has now completed thirty years of continuous publication. The chief aim of the journal has been to help create a medical terminology and literature in the language of the Bible. In addition, it has presented many important original medical studies on the medicine of the Bible, Mishnah and Talmud, as well as the role played by Jewish physicians in the history of medicine throughout the ages.

The journal, *Harofe Haivri*, as it is called in its native tongue, comes out twice a year. It has an English language section, which summarizes the scientific articles and includes additional data of interest to English speaking physicians. The journal includes fresh scientific articles, many book reviews, a pharmaceutical section, editorials and other items. For more information write to the Hebrew Medical Journal, 983 Park Avenue, New York 28, N. Y.

Trustees' Meetings

April 20, 1958

At its April 20 meeting, the Board rose and stood for a moment of silent prayer in tribute to the memory of our President, Dr. Albert B. Kump who had passed away 48 hours before the meeting. The Board then unanimously adopted the following resolution and ordered it sent to Mrs. Kump:

Whereas, Almighty God in His omniscience has seen fit to summon from our midst Albert Barker Kump, M.D., 165th President of The Medical Society of New Jersey, and

Whereas, By his high character and exemplary life both as a man and as a physician, Doctor Kump has ever been a model and a genuine inspiration to all who knew him, and

Whereas, By his vision, initiative, and skill he has for long years and in many capacities rendered outstanding service to his profession and to his fellowmen, and

Whereas, As by his life we were all enriched so by his death we are all impoverished, therefore be it

Resolved, That The Medical Society of New Jersey, honoring him in death as in life, record its profound grief at his passing; and be it further

Resolved, That a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to his bereaved family.

The Board then took the following actions:

—Ordered that there be a posthumous presentation of Dr. Kump's Fellowship Key at the opening session of the House of Delegates.

—Cancelled the Annual Meeting dinner dance.

—Established an Albert Barker Kump Memorial Grant in the Medical Student Loan Fund.

—Instructed the Administrative Secretary to purchase a silver tray in memory of Dr. Kump, the cost to be met by the Trustees personally.

—Ordered a special session on social security and the physician for the Annual Meeting.

—Adopted a resolution urging Medical-Surgical Plan to continue limiting payments to persons holding full licenses to practice medicine.

—Adopted a resolution which recommended to the members that they limit participation in non-profit service benefit medical insurance plans, to those plans whose Boards are composed of majorities of physicians who have been approved by their State Medical Societies and whose contracts have provisions, schedules of benefits, and income limits which have been approved by the State Medical Society in the State in which the corporation is chartered.

—Disapproved the request of a community hospital to have our Executive Offices address envelopes to our membership to distribute a brochure describing a new hospital facility. Dr. Gardner voiced objection to making available to any organization the mailing list of the Society; he felt the list should be available only to members of the Society. The chairman pointed out that by a previous Board ruling, all requests for membership mailings must be brought to the Board for individual action.

—Named Dr. Richard Gordon of Englewood as our Society's representative to the Governor's Commission on Mental Health Legislation.

—Approved of the naming by the President, of Dr. L. S. Wegryn of Elizabeth and Dr. C. H. Calvin of Perth Amboy to the Joint Commission on Fluoridation.

—Approved of our Society's cooperation with the State Health Department's cancer program, and specifically with the radiation symposium to be held at the Newark Presbyterian Hospital in May.

—Authorized Dr. Blaisdell to attend the seminar of the Society of Medical Technologists as our representative.

—Recommended a one-time supplemental grant of $15,000 to the American Medical Education Foundation in recognition of the honor bestowed on this Society by the election of one of our members to serve as AMA President.

—Approved a 1958-9 budget of $193,299.

—Approved a 1959 assessment of $30 per capita.

—Took action on certain legislative proposals.*

*See list of bills beginning on page 311 and again on page 314.

—Authorized an increase in the surety bond taken out in connection with reimbursement under the Medicare Program.

—Authorized the Medicare Committee to postpone renegotiation of the contract until September.

—Authorized, for the official activities of the Executive Officer, the purchase of a new 1958 Chevrolet 4-door sedan.

—Approved of the following nominations for membership on the Board of Governors of Medical Service Administration and referred the names to our House of Delegates for action: Messrs. A. W. Lunn and J. S. Thompson; and Doctors H. N. Comando, W. F. Costello, R. A. Schaaf, R. C. Schretzmann, Edward W. Sprague and Thomas J. White.

—Approved of the following nominations for membership on the Board of Trustees of Medical-Surgical Plan and referred the names to the House of Delegates for action:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Robert G. Boyd
Harry N. Comando, M.D.
Patrick H. Corrigan, M.D.
William F. Costello, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Joseph M. Keating, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Duane E. Minard, Jr.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
James H. Spencer, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

—Reviewed a letter from the secretary of the State Board of Medical Examiners concerning our Board's resolution of March 2, 1958, on nurses giving intravenous medications. A copy of this resolution had been sent by the Nurses' Association to Deputy Attorney Andrew A. Salvest, legal advisor to the Nursing Board and to the Board of Medical Examiners. Mr. Salvest informed the Board of Medical Examiners "that the resolution affects the interpretation of the Medical Practice Act. It is our opinion that the Medical Society is not the proper authority to interpret the Act."

The Nurses' Association had originally requested that the Society assist in amending the law to permit nurses to give intravenous medications. Since the present situation affects the practice of every hospital, Dr. Blaisdell moved—seconded by Dr. Bowers, and carried—that the matter be referred to the Subcommittee on Legislation with the idea of seeing what might be necessary to effect a change in the Medical Practice Act.

—Authorized a 10 per cent increase in advertising rates in this JOURNAL.

—Expressed appreciation to Mr. Backes for refusing an extra fee for attending the AMA medico-legal conference in Chicago. It is specified in his arrangement with our Society, that Mr. Backes' retainer is to be supplemented by additional fees for "extraordinary services."

May 16, 1958

The Trustees met on May 16, 1958. The Board considered at length a proposed guide for the government of relations between the medical profession and the newspapers. A motion was passed approving of the guide.

The Board referred to the Judicial Council the problem of defining "voluntarily associated activity" for characterizing relationships between physicians and osteopaths.

The President of the Medical Society was authorized to accept appoint to the Governor's Committee on Employment of the Handicapped.

Announcement was made of the establishment of the Albert B. Kump memorial grant in the medical student loan fund. A total of $780 from 41 individuals had been received. Two county medical societies and two county auxiliaries have also contributed. The goal is $5,000.

The Trustees approved the position taken on legislative matters by the subcommittee on legislation. See page 314.

A silver tray, a memorial to Dr. Kump, suitably inscribed and purchased as a personal contribution by the individual members of the Board of Trustees, was exhibited at this meeting.

The Board issued an invitation to the American Medical Association to meet in Atlantic City in 1963.

The Board referred to our Delegates a proposal of the Texas State Medical Association concerning objections to the Medicare program.

May 20, 1958

The Trustees met on May 20, 1958 for the reorganization meeting. Dr. Ware was elected

Chairman of the Board for 1958-59, and Dr. Wegryn Secretary for 1958-59. Dr. Lewis Fritts was continued on the Board as immediate Past-President for another year.

The Board voted a letter of appreciation to Dr. Royal A. Schaaf for the services rendered by him as retiring trustee. All salaried employees, full time and part time, in the editorial, legal and executive staffs were reappointed.

The President, President-Elect, Secretary, one Alternate Delegate, and the Executive Officer, were authorized to attend the AMA meeting in San Francisco, all expenses paid.

The Board adopted several resolutions expressing appreciation to personnel for the successful Annual Meeting. Those thus accoladed included Dr. Jerome Kaufman, Chairman of the Annual Meeting Committee, staff of Haddon Hall Hotel and other personnel.

Welfare Committee Session of April 13, 1958

At its April 13 session, the Welfare Committee heard a paper by Dr. D. O. Meeker of Connecticut on the Forand Bill. The paper was entiled "The Forand Bill: Socialized Medicine at its Worst." Dr. Meeker is a member of the A.M.A. Committee on Legislation. He outlined the major revisions to the present Social Security Act, analyzed the salient features of H.R. 9467, and suggested many reasons for opposing it. The most pertinent reasons for opposition are:

1. It would strangle the growth of voluntary health insurance.
2. The job of providing hospital and surgical services for the older population can be handled by voluntary means.
3. Why provide free hospitalization and surgery for all old age survivors' beneficiaries when a large proportion of them don't need free care?
4. It means Government would control standards of hospital and surgical services provided under the law.
5. It would conflict with American free competitive enterprise in the hospital and medical care field.
6. The individual entitled to service benefits under the law would be restricted in his choice of hospital and physician.
7. The personal relationship between the doctor and his patient would be harmed.
8. It would change the basic concepts of the social security program.
9. The door would be opened wide for abuse of hospital and medical services.
10. Over-utilization of hospitals would limit the number of beds available for the acutely ill in the community.
11. Community incentive to support voluntary hospitals would be curbed.
12. The Government would assume the role of price and wage fixer.
13. It would provoke imaginary illness.
14. It would discourage families from taking care of their own.
15. It would mean a larger bite from the paycheck of the working man.
16. It would create a clamor for similar benefits from other age groups.

It was Dr. Meeker's final suggestion that in order to defeat H. R. 9467, medical societies voice their objections to the members of the House Ways and Means Committee.

Representing the Health Insurance Council, Ardell T. Everett, Second Vice-President of the Prudential Insurance Company of America, addressed the committee briefly on the economic effect of the Forand Bill, should H. R. 9467 be enacted into law. A discussion period followed.

The Committee considered the following legislative proposals:

SUBCOMMITTEE ON LEGISLATION

STATE LEGISLATION

S-85 *Fox*—To authorize the Health Department to establish a program to control virus diseases and for the Division of the Aging. APPROVED.

S-106 *Stout*—To create a Commission on Radiation Protection to formulate and enforce a program of public education concerning radiation. APPROVED.

S-131 *Hannold, Ridolfi*—To make hypertension, heart disease, tuberculosis, and permanent disability sustained in the line of duty compensable under the retirement system established by Chapter 253, P. L. 1944. DISAPPROVED . . . because it involves diagnosis by

legislative enactment rather than by medical investigation.

S-132 *Hannold, Ridolfi*—Companion bill to S-131. DISAPPROVED . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

S-133 *Hannold, Ridolfi*—Companion bill to S-131. DISAPPROVED . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

A-188 *Kesselhaut*—To regulate the practice or profession of electrology (superfluous hair removal); requires the State Board of Medical Examiners to set up standards of education and practice, and to license those engaged in the profession. ACTION DEFERRED . . . pending a report on the bill by the State Board of Medical Examiners.

A-189 *Meloni*—To amend the Workmen's Compensation Act to provide that an injured employee shall be supplied with reports from the treating doctor and hospital. DISAPPROVED . . . because such a requirement would involve a duplication of effort, and, in some instances, would be disadvantageous to the welfare of the patient.

A-250 *Musto, Kijewski*—To provide for the licensing of establishments used in ophthalmic dispensing. APPROVED.

A-253 *Miller, Wilson, Hughes*—To amend the law governing medical services corporations to eliminate requirements that a corporate trust shall be approved by a recognized medical society and that 51 per cent of the licensed physicians in the county must participate before the corporation may transact business there. ACTIVE OPPOSITION . . . because it would eliminate the requirements originally insisted upon by the State Commissioner of Banking and Insurance which serve as a guarantee of the quality and adequacy of available medical care for subscribers under the contemplated plans.

A-281 *Ronco, LeWine*—To provide that any person holding a license to practice medicine and surgery as an osteopath, issued by the State Board of Medical Examiners, who was thereafter admitted, with advanced standing, to an approved medical school, completed the school's requirements, and was granted a degree of Doctor of Medicine and thereafter shall have served an acceptable internship in a hospital approved by the Board of Medical Examiners, shall have professional educational qualifications entitling him to admission to examination for a license to practice medicine and surgery. DISAPPROVED . . . because it does not define premedical training, and would allow an individual to qualify under lesser circumstances than those presently stipulated under the Medical Practice Act.

A-301 *Swick*—To define "patent and proprietary medicines" and the term "non-poisonous" in the Pharmacy Act. DISAPPROVED . . . because the subcommittee considers that it is contrary to the public interest, that the manufacturer be the sole arbiter of what is "non-poisonous." The Medical Society of New Jersey looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would encourage self-medication by the public.

A-313 *Musto, Hauser*—To eliminate the requirement that consent of the defendant in a drunken driving violation to chemical analysis tests shall be express consent. APPROVED IN PURPOSE AND INTENT WITHOUT COMMITMENT AS TO CONSTITUTIONAL IMPLICATION.

A-346 *Farrington*—To provide that any person who knowingly sells, offers for sale, buys, exchanges, possesses, or gives away any fire extinguisher containing carbon tetrachloride is a disorderly person. DEFERRED ACTION . . . pending receipt of information from sponsor of bill.

A-356 *Laufer, Ronco, LeWine*—To authorize the Department of Health to establish a program to control virus disease and for the Division of the Aging. APPROVED.

A-70—To provide certain hospital, medical, and surgical benefits to state employees with costs to be borne by the State.

The subcommittee originally recommended the position of "Approved in Principle with the Proviso . . . that the phrase 'in any non-profit hospital service and medical service plan' be reworded to read 'in any private incorporated hospital service and medical service plan.'"

The Trustees directed the subcommittee to restudy A-70, calling particular attention to sections which reportedly would set the income limit at $5,000 and would legislate the 1949 M.S.P. schedule of benefits. Professional fees cannot be legislated, and any such plan should provide for a participating physician's agreement and an up-to-date income limit and schedule of benefits.

The Legislative Analyst reported he was unable to accept the above conclusions in regard to this bill. He stated that the language makes it apparent that the physician would *not* be limited to payment by the state services, but would be entitled to whatever balance might be due him from the employee to whom the services might be rendered. He further pointed out that the State has a right to limit its obligation under any services which it might conclude to render its employees. In this bill it does not purport, however, to limit the obligation of the employee to the doctor, but rather to limit the obligation of the State to the attending physician.

On advice of our Legislative Analyst and after reconsideration, the subcommittee reaffirmed its original position ("approved in principle"). The Trustees subsequently concurred in this position.

In addition to legislative matters, the following items were considered by the Welfare Committee.

SUBCOMMITTEE ON MEDICAL PRACTICE

The Committee — and, subsequently — the Trustees—approved of having our Subcommittee on Medical Practice make a study of fee schedules in a project with New Jersey specialty societies. It is understood that this "approval" means endorsement of the study project, not approval of the idea of a fee schedule.

Workmen's Compensation Fees—Through the subcommittee it was reported that the State has adopted the rigid fee schedule of Blue Shield as the basis for all payments of workmen's compensation cases of state employees. (R.S. 34:15-15, Medical and Hospital Services: "All fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons', and hospital services.")

The following recommendation of the subcommittee was approved by the Welfare Committee. The Trustees referred it to the Special Committee on Workmen's Compensation:

That an immediate investigation be made of the practice of the State Workmen's Compensation Division in arbitrarily adopting the fee schedule of Blue Shield as the basis for all payments in workmen's compensation cases of state employees; and that corrective measures be initiated.

The Committee considered the question of fee differentials between specialists and general practitioners.

It was the consensus that a *bona fide* specialist is entitled to receive more for his services than a non-specialist, and that specialist ratings would prevent the non-specialist from capitalizing on some things to the detriment of the patient. The subcommittee also felt that until The Medical Society of New Jersey recognizes specialists as such, individuals cannot be expected to recognize them.

In the form finally approved by the Trustees, the acceptable and adopted recommendation was:

That The Medical Society of New Jersey recognize specialists so far as they are designated by their component societies by assigning their specialist's rating to each physician.

SUBCOMMITTEE ON PUBLIC HEALTH

The Special Committee on Mental Health reported continued concern with borderline practitioners, especially as they affect psychiatry, and the Subcommittee on Public Health went on record as expressing grave concern over the inroads in the field of medicine made by borderline practitioners endeavoring to achieve status in the field of medicine.

The following recommendation of the subcommittee was approved by the Welfare Committee and by the Board of Trustees.

"The subcommittee wholeheartedly supports the specialty groups which are trying to stop these inroads, and calls upon the Welfare Committee to forward this to the Board of Trustees for appropriate action through the instrumentality of the State Board of Medical Examiners."

Special Committee on Conservation of Hearing and Speech—The following recommendation was approved by the Subcommittee on Public Health, by the Welfare Committee and by the Board of Trustees.

That there be a thorough investigation into the possibility and advisability of encouraging the establishment in New Jersey of a center for the training of audiologists and speech pathologists, with programs leading to a doctoral degree.

The Welfare Committee and the Trustees approved the following resolution:

Inasmuch as sunglasses are a dangerous handicap to vision after dusk, it is recommended that—especially as a means of avoiding accidents involving pedestrians and motorists alike—sunglasses be not worn after sundown.

Veterinary Medical Association—In consideration of a request from the Veterinary Medical Association of New Jersey, the subcommittee approved liaison between The Medical Society of New Jersey and the Veterinary Medical Association of New Jersey. The following recommendation of the subcommittee was approved by the Welfare Committee and by the Board of Trustees.

That a veterinarian be appointed as a consultant to the Subcommittee on Public Health, to permit the Veterinary Medical Association of New Jersey to bring pertinent matters to the subcommittee's attention.

Tetanus Toxoid—The subcommittee reported that failure of parents to obtain tetanus toxoid booster shots every five years for their children is a serious health hazard. The following recommendation of the subcommittee was approved by the Welfare Committee and by the Board of Trustees.

That the Subcommittee on Public Relations be requested to remind the public that tetanus toxoid booster shots should be given to children every five years.

Subcommittee on Legislation

The Subcommittee has recommended, and the Trustees have concurred, in our taking the following position on bills of medical interest.

S-23—To increase the penalties for narcotic violations. *No action.*

S-40—To permit issuance of marriage licenses to certain epileptics. *Approved.*

S-44—To permit municipalities to require that all garbage be disposed of by sanitary landfill or incinerator methods. *Disapproved.*

S-55—To permit the sale of certain patents or proprietary medicines by general merchants. *Disapproved.* (Disapproval also applies to S-64 and A-23, which are similar in content.)

S-86—Establishing a virology program within the State Department of Health. *Action deferred.*

S-106—To create a Commission on Radiation Protection. *Action deferred.*

A-5—To permit an injured employee to select his own physician for treatment under Workmen's Compensation Act. *Approved.*

A-70—To provide that the State bear the costs of certain hospital medical and surgical benefits for its own employees. *Approved in principle* with the understanding that it will apply to any private incorporated hospital service and medical service plan.

A-178—To exclude ophthalmic technicians from the provisions regulating ophthalmic dispensers. *Disapproved.*

A-183—To allow humane societies to enforce certain provisions of the law against cruelty to animals. *Disapproved.*

A-188—To regulate the practice of electrical removal of superfluous hair. *Action deferred.*

A-222—To prescribe mandatory imprisonment for persons who use a child for the sale of narcotics. *No action.*

A-229—To provide that certain diseases, such as hypertension, tuberculosis, and heart disease, incurred by firemen shall be considered to be occupational diseases. *Disapproved.*

Virology Program Activated

A program in virology was activated in May, 1958 in the State Department of Health after budgetary support was assured. For several years, limited virus diagnostic services have been available to physicians and health officers, such as for poliomyelitis, influenza virus isolation, and serologic tests for the common viral and rickettsial diseases. Activation of a more comprehensive virology program will add an expanded list of services in a field which is rapidly developing new diagnostic methods for routine use.

To obtain the most satisfactory results from these services, it is essential that specimens to be examined be obtained properly and submitted to the Department laboratories under conditions outlined below:

TYPE OF SPECIMEN

Virus isolation—Materials for isolation must be freshly obtained and if possible collected with aseptic precautions. Usual materials include blood, throat washings, sputum, feces, effusion fluid, tissue biopsies, autopsy tissue, or lesion scrapings. No preservative or fixative should be added.

Serologic tests—Serum is to be obtained from clotted blood collected and kept under sterile conditions. No preservative is added. Serum separated from clot at source prevents hemolysis. At least 20 milliliters of blood (10 ml. of serum) should be collected for serologic tests.

TIME TO COLLECT

Virus isolation—The earlier in the acute stage the specimen is taken the better the chance for successful isolation.

Serologic tests—Serum specimens *must be paired* since only a *rise* in specific antibody titer is positive evidence of current infection with the responsible agent. The first sample should be collected as early in the illness as possible and the second from 2 to 8 weeks after the beginning of convalescence. Best method is to take a series of samples: acute, 2 and 4 week convalescent.

CONTAINERS

Virus isolation—Materials for virus isolation must be frozen if it will take longer than a few hours to get them to the laboratory. This requires dry ice. These specimens must be completely sealed off (flame-sealed ampules for fluid specimens). Place tissue samples in bottles closed with tightly fitting rubber stoppers. The tops should be sealed over with paraffin or other suitable material. If facilities for freezing tissue specimens are not available, place tissue in 50 per cent buffered glycerine.

Serologic tests—The container must protect the specimen from loss of breakage as well as from contamination and deterioration. Serum samples in test tubes with tight rubber stoppers (reinforced by adhesive tape) or leakproof screw top vials are satisfactory.

PACKING AND SHIPPING

Virus isolation—Virus isolation samples once ampuled should be quickly frozen (on dry ice) and kept frozen at minus 10 degrees centigrade or lower, until shipped.

Serologic tests—Serum samples for serologic tests may be shipped without refrigeration in ordinary containers protected against spillage and breakage. These specimens should be sent by the most rapid method.

Data to be supplied with specimen: Indicate (1) Name of patient; (2) Age; (3) Summary of pertinent history, physical findings, and clinical laboratory tests with dates; (4) Type of material submitted and date collected; (5) Disease suspected; (6) Similar cases in family or vicinity? (7) Vaccines given to patient; (8) Any exposure to animals? and (9) Antibiotic treatment, if any, given to patient.

INTERPRETATION OF TESTS

Virus isolation: Failure to isolate a virus does not rule out that agent, or an unsuspected one, as the possible cause of the illness. When a virus is isolated, it signifies current *infection* (which may be silent) with that virus. It usually, but not always, means that the current apparent *illness* is due to that virus. The results of virus isolation attempts must be correlated with the clinical, epidemiologic, and serologic data.

Serologic tests: Some individuals already have antibodies against certain viruses because of previous contact with that virus. *The finding of antibodies in a single serum sample taken during or after a particular illness does not prove the etiology of that illness.* However, a definite (4-fold or higher) rise in antibody titer from the acute stage of the disease to convalescence is usually significant. Although serologic tests yield indirect evidence of virus activity, they are more frequently informative than virus isolation attempts. An effort should be made in *all* cases to submit *paired* serum specimens to make a presumptive serologic diagnosis or to confirm the significance of the virus isolation by demonstrating a rise in antibody titer against the virus during the course of illness.

There are certain occasions when a *third* serum specimen (late in convalescence, 2 or 3 months after onset) is valuable. This is a necessity in lymphocytic choriomeningitis and most rickettsial diseases. In lymphocytic choriomeningitis, complement fixing antibodies may not occur until late in the course of the disease, approximately in the eighth week. In rickettsial diseases and in psittacosis and lymphogranuloma venereum the production of complement fixing antibodies may be suppressed or delayed in patients who are treated early with broad spectrum antibiotics.

192nd Annual Meeting — May 17 - 21, 1958

Haddon Hall, Atlantic City

Official Attendance

County	Delegates	Members	Total
Atlantic	10	68	78
Bergen	37	28	65
Burlington	5	14	19
Camden	21	53	74
Cape May	3	7	10
Cumberland	5	18	23
Essex	69	188	257
Gloucester	4	15	19
Hudson	25	51	76
Hunterdon	3	7	10
Mercer	26	53	79
Middlesex	14	26	40
Monmouth	19	49	68
Morris	15	16	31
Ocean	4	10	14
Passaic	23	41	64
Salem	3	11	14
Somerset	6	12	18
Sussex	3	2	5
Union	34	64	98
Warren	3	5	8
Fellows, Officers, Trustees, Councilors	19		19
	351	738	1,089
Physician Guests			85
Physician Exhibitors			19
TOTAL PHYSICIAN REGISTRATION			1,193
Auxiliary Members			401
Visitors			295
Exhibitors			254
TOTAL REGISTRATION			2,143

FIVE YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Totals
1958	1,193	950	2,143
1957	1,202	909	2,111
1956	1,238	947	2,185
1955	1,040	790	1,830
1954	1,231	996	2,227

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigations, judged on the basis of originality and excellence of presentation:

First Place: The "Mechanical Heart"—and Indications for Its Use

Alfred R. Henderson, M.D., Harvey Black, Robert Meijer, Ph.D., and Lucy Aiello, M.T., Asbury Park

Second Place:The Practical Diagnosis of Surgical Heart Disease

Julio C. Davila, M.D., Robert G. Trout, M.D., and Robert P. Glover, M.D., Presbyterian Hospital, Episcopal Hospital, and St. Christopher's Hospital for Children, Philadelphia, Pa.

Honorable Mention: Pneumoperitoneum as a Diagnostic Aid in the Diaphragmatic Area

Bernard Maisel, M.D., Nathaniel Finby, M.D., and John A. Evans, M.D., New York Hospital-Cornell Medical Center, New York, N. Y.

Class II—New Jersey Exhibitors:

First Place: Common Pathologic Lesions—Plastic Wet Mounts in Natural Color

Martin R. Rush, M.D., George T. Hoffmann, M.D., and Alfredo D. Zavaleta, M.D., Monmouth Memorial Hospital, Long Branch

Second Place: Carbohydrate Metabolism in Pregnancy

Milton Gross, M.D., Joseph P. Donnelly, M.D., and Gerald J. E. Ansell, M.D., Margaret Hague Maternity Hospital, Jersey City

Honorable Mention: Experimental Production and Prevention of Cleft Palate Deformity in Mice and Its Application to Humans

Lyndon A. Peer, M.D., Walter Ryan, Ph.D., John C. Walker, M.D., Lyon P. Strean, D.D.S., Alvin Mancusi-Ungaro, M.D., and Michael B. Colitto, D.D.S., St. Barnabas Medical Center, Newark

Obituaries • • •

DR. PATRICK H. CORRIGAN

A coronary occlusion on May 28, 1958, took the life of Dr. Patrick H. Corrigan, one of the state's best known medical officials. He was secretary of our State Board of Medical Examiners and also a trustee of our Medical-Surgical Plan. Born in Newark in 1901, Dr. Corrigan was graduated in 1923 from the medical school of Georgetown University in Washington. He started in general practice but became increasingly interested in internal medicine and in 1948 was made a diplomate of the American Board of Internal Medicine. He worked up through various staff grades at St. Francis Hospital in Trenton and, at the time of his death, was chief of the medical service there.

DR. ROBERT A. GIULIANA

At the venerable age of 81, Dr. Robert A. Giuliana died on May 28, 1958. Dr. Giuliana was graduated in 1898 from the Long Island College Hospital, and opened his office in Newark the following year. He served the people of Newark from the Spanish-American war through the days of World War II. In 1927 he moved his residence to Monmouth Beach, but for 30 years commuted daily to Newark where he maintained his office until his retirement last year. Dr. Giuliana was one of the founders of St. James Hospital. He served the Red Cross in both World Wars. In World War 1, indeed, he was stranded in France (where he was visiting) in 1914 and served as a volunteer surgeon for the Red Cross there. He had a term as president of the New Jersey Physicians' Art Association and was known as a gifted artist, pianist and sculptor. He was also a Patron of the Smithsonian Institution.

DR. EVERETT W. PROBST

Dr. Everett W. Probst was born in Jersey City in 1905 and died in Dover on May 22, 1958. He received his B.A. degree from Lafayette College in 1926 and his M.D. from the medical school of New York University in 1930. After a brief period of private practice, he became interested in industrial surgery and occupational medicine. He was the inventor of a plastic surgical splint which brought a prize award some years ago. For some time he was secretary to the N. J. Industrial Physicians' Association. He was active in the affairs of the American Academy of Occupational Medicine. He was a Lieutenant Colonel in the Army in World War II. For many years he supervised the medical program for New Jersey plants of DuPont. At the time of his death, he was medical director of Reaction Motors.

DR. CECIL C. SHEETS

Dr. Cecil C. Sheets of Paulsboro died suddenly on May 26, 1958. A native of Canada, Dr. Sheets was graduated from McGill University's medical school in 1923. After an internship in Canada, he came to the United States and, in 1924, he opened his office for general practice in Paulsboro. He thereafter served the people of Gloucester County for more than three decades. He was school physician for Gibbstown as well as for Paulsboro and had a term as coroner of Gloucester County. Dr. Sheets was president of the Gloucester County Medical Society and active in a local Sportsman's Association. He was 57 years old at the time of his death.

DR. OTTO CARL TOMEC

Death came on June 14, 1958 to Dr. Otto Carl Tomec, chief of cardiology at Trenton's McKinley Hospital. Born in Lancaster, Pennsylvania in 1908, Dr. Tomec received his baccalaureate degree at Lafayette College in 1929 and his M.D. at Philadelphia Hahnemann in 1933. A Fellow of the American College of Cardiology, Dr. Tomec was active in the American Institute of Homeopathy. At one time he was medical director of the McKinley Hospital. He was also one of the best known amateur golfers in the United States. He had competed in the U. S. National Amateur Golf Tournament and finished in second place in a nationwide competition in 1952 under the auspices of the Shriners. He was champion golf player at the Trenton Country Club for many years.

Announcements • • •

Occupational Medicine

New York University announces a new part-time course, "Occupational Health for Physicians," (4814-A) Thursdays, 2 to 5 p.m., from September 18, 1958 to May 14, 1959. This will be an intensive survey of occupational health, designed to meet the requirements of physicians unable to take a full-time program.

Among the topics covered are: administration of an industrial medical department; preventive and constructive medicine in industry; occupational diseases; toxicology; industrial hygiene for the physicians, biostatistics and epidemiology. Tuition is $300.

For further information and applications write: Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Annual Cancer Seminar

The New Jersey Division of the American Cancer Society will hold its Sixth Annual Cancer Seminar on November 9, 1958. It will be a one-day session at the Essex House in Newark. Prominent authorities will speak on cancer diagnosis and therapy.

For more details, write to Executive Director, American Cancer Society, N. J. Division, 9 Clinton Street, Newark 2, N. J.

Identification Card for Cardiac Patients

An "emergency" identification card for the protection of patients on long-term anticoagulant therapy is now available to physicians from the New Jersey Heart Association. This wallet insert was developed as a result of requests from physicians seeking to protect their patients on anticoagulants in case of accident, dental surgery or other treatment that may induce bleeding. It points out that the bearer "is being treated with anticoagulants which slow down clotting of the blood." In case of emergency—bleeding, injury or illness—the card advises that a doctor be called, since the patient may require an antidote.

The card contains space for the name, address and phone number of the individual's physician. Space also indicates the patient's blood type and kind of anticoagulant prescribed.

Physicians may obtain these cards from the New Jersey Heart Association, 60 Park Place, Newark 2.

Obstetrics and Gynecology Board

Applications for certification by the American Board of Obstetrics and Gynecology (new and reopened) Part I, and requests for reexamination Part II are now being accepted. Make application at the earliest possible date. Deadline for receipt of applications is August 31, 1958. No applications can be accepted after that date. Next year the deadline will be August 1, 1959.

Write to the address below for a current *Bulletin* so that you are well informed about present requirements. Application fees ($35), photographs, and lists of hospital admissions must accompany all applications.

Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

Disaster Tags Now Available

A standardized "disaster tag" is now available.* It is made in triplicate, with a length of cord for tying to the patient. It is usable for fire, explosion, tornados, train wrecks—any event that may bring a rush of patients in to your hospital. Interleaved carbon copies save time and temper. There is sensible space for recording diagnosis, disposition, and priority

*From the Physicians' Record Company at 161 West Harrison St., Chicago 5, Illinois.

County Society Reports • • •

Hudson

The annual meeting of the *Hudson County Medical Society* terminating the official year of 1957-8 was held at Jersey City Medical Center on May 6, Dr. Harold Gorenberg presided.

Elected to Active membership was Dr. Alexander J. Povalski, Jr. of Jersey City.

The following officers were elected to serve during 1958-59: Dr. John J. Bedrick—President, Dr. Charles E. Rosen—President-Elect, Dr. Charles A. Landshof—Vice-President, Dr. Nathan J. Plavin—Secretary, Dr. Matthew E. Boylan—Treasurer, and Dr. Clement M. Jones—Reporter.

Guest speaker was Dr. Wilfred F. Ruggiero, Associate Professor of Surgery, New York Medical College. He talked on "The Treatment of Gastrointestinal Hemorrhage and Ascites Associated with Liver Cirrhosis." Dr. Carroll M. Leevy participated in a discussion from the floor.

CLEMENT M. JONES, M.D.

Reporter

Monmouth

Dr. Louis R. Wasserman was guest speaker at the regular meeting of the *Monmouth County Medical Society* on May 28, at Monmouth Memorial Hospital. Dr. Wasserman is Director of Hematology, Mt. Sinai Hospital, New York, and Associate Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons. He gave an excellent discourse on "Polycythemia and Myeloproliferative Syndromes."

The business meeting was under the direction of the President, Dr. Theodore Schlossbach. A resolution was adopted honoring the late Dr. Charles D. Prout for his many years of service to medicine and the community.

Drs. Jerald R. Cureton, New Shrewsbury, and Robert R. Reilly, Sea Girt, were elected to Active membership. Associate membership was granted to Drs. Edward Allegea, Red Bank, and Joseph W. Schauer, Farmingdale.

DONALD W. BOWNE, M.D.

Reporter

Middlesex

The annual social outing of the *Middlesex County Medical Society* was held on Wednesday, May 14, at the Forsgate Country Club in Jamesburg. Several of the members played golf and at 6:00 p.m. a dinner was enjoyed by the doctors, wives and guests.

A short business meeting was called to order by the President, Dr. Gessner.

Dr. Malcolm Dunham, in the absence of Dr. B. F. Slobodien, reported for the Judicial Medical Ethics Committee. Applicants accepted were:

To Regular membership by transfer from the Medical Society of County of New York—Dr. Victor L. Karren, New Brunswick; Two-year Associate membership—Dr. H. Stephen Brody, New Brunswick.

The purchase of plaques to be presented to past presidents of the County Medical Society was referred to the Board of Trustees.

On request, Dr. Charles Hendee Smith was transferred to Emeritus membership.

Dr. Gessner commented on the membership in other state Blue Cross and similiar plans. The members felt that they should become participating physicians only in Plans approved by The Medical Society of New Jersey.

The meeting was adjourned at 9:00 p.m.

M. G. MATFLEID, M.D.

Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held on Tuesday, May 27 at 9:00 p.m. at the Medical Society Building. The meeting was presided over by Dr. Samuel C. Yachnin, the President.

Dr. John J. Jennings of Clifton was elected to Associate membership.

In the absence of the Secretary, Dr. Yachnin read resolutions on the death of two members, Dr. Martin Nemirow and Dr. Alberico Masucci. Both resolutions were adopted as read.

The President reported on several items of special interest to our members in connection with the activities of the State Convention in Atlantic City, as follows:

1. Thirteen of our County Emeritus Members were granted the status of Emeritus Member of The Medical Society of New Jersey.

2. The members of our County Society who received the Golden Merit Award this year for having completed fifty years of practice, were: Drs. Hagop K. Beshlian, William M. Fielding, John H. Gould, Ernest Reeves, and William Tomkins.

3. Medical Society of New Jersey dues for 1959 will be reduced to $30 instead of the former $40.

4. In connection with the resolutions on the Medical-Surgical Plan, Dr. Yachnin said that they found there were a few inequities and a compromise was made whereby the matter was referred to the legal counsel of The Medical Society of New Jersey for deliberation.

Dr. Yachnin then called upon Dr. Joseph E. Mott, as a member of the State Nominating Committee, who was pleased to report that Dr. Joseph R. Jehl had been elected to serve as a member of the Board of Trustees of The Medical Society of New Jersey.

In the absence of the chairman of the nominating committee of the Society, Dr. Jehl, a member of the committee, read the report of the committee as follows:

President—Theodore K. Graham
First Vice-President—Julian Cohen
Second Vice-President—F. Albert Graeter
Secretary—Joseph E. Mott
Treasurer—Frank B. Vanderbeek
Reporter—David B. Levine
Board of Censors (3 years)—Samuel C. Yachnin
Building Trustees (3 years)—Leon E. De Yoe, Wayne W. Hall, Dean A. Wry and Leopold E. Thron.

The President called for nominations from the floor. There being no nominations, it was moved, seconded and passed that the nominations be closed, and the Secretary cast a ballot and the slate be unanimously elected.

The President then turned the meeting over to Dr. Samuel R. Deich who introduced the speaker, Irvin Klein, M.D., Compensation Examining Physician, New York State Compensation Board; Chairman, Rehabilitation Commission New York Heart Assembly; Instructor, Medicine, New York Medical College, New York. Dr. Klein's subject was "Rehabilitation of the Cardiac." A question period followed.

DAVID B. LEVINE, M.D.

Reporter

Salem

The annual meeting and shad dinner of the *Salem County Medical Society* was held May 24, 1958, at the Country Club of Salem. Dr. W. Garrett Hume, retiring president, gave a summary of the year's activities and introduced the new president, Dr. Charles E. Gilpatrick, and the other officers. He then introduced Dwight F. Palmer, Ph.D., of Woodstown, who talked about South Jersey Indian lore. Dr. Palmer showed specimens from his collection of Indian relics found in this region and explained how these objects reflected the culture and habits of the people of that time.

The dinner and the talk were equally enjoyable. While members are always glad to have professional edification through lectures, it was agreed that this kind of talk was something fresh, interesting and culturally enriching. It is also unusual. The speaker was given a well merited, rising vote of thanks.

W. L. SPROUT, M.D.

Reporter

New Jersey Society of Pathologists

At the annual meeting of the *New Jersey Society of Pathologists* the following were elected to serve as officers for the ensuing year: Robert Brill, M.D., President; Aaron P. Gewanter, M.D., Vice-President; George L. Erdman, M.D., Secretary; J. P. Greeley, M.D., Treasurer.

Appointed to serve with the officers on the Executive Committee are: Murray Shulman, M.D.; Harold Grubin, M.D.; E. Olmstead, M.D., and Edward Fendrick, M.D.

MURRAY SHULMAN, M.D.

Chairman, Publicity Committee

Radiological Society of New Jersey

The following officers were elected for the year 1958-59 at the annual meeting, held in Atlantic City on May 20:

President—Dr. George G. Green; Vice-President—Dr. William L. Palazzo; Secretary—Dr. Andrew P. Dedick; Treasurer—Dr. W. Laurence Bonnet.

The meeting dates of the Society remain the same: Annual Meeting in Atlantic City in April; Fall Meeting in Newark in October or November.

ANDREW P. DEDICK, M.D.

Secretary

Society for the Relief of Widows and Orphans

The annual meeting of the *Society for the Relief of Widows and Orphans* was held May 1 at the home of Dr. Earl LeRoy Wood, Ballantine Parkway, Newark. The following members were elected to the offices indicated:

President—Earl LeRoy Wood, M.D., Newark; Vice-President—Berthold T. D. Schwarz, M.D., Montclair; Treasurer—Harold A. Tarbell, M.D., Newark; Assistant Treasurer—James E. D. Gardam, M.D., Glen Ridge; Custodian—Herbert A. Schulte, M.D., Newark; Secretary—Joseph William Gardam, Sr., M.D., Newark.

Trustees—3 years: Alfred Stahl, M.D., Newark; George Sommer, Jr., M.D., Trenton; Franklin J Tobey, M.D., Newark.

Trustees—2 years: Stuart Hawkes, M.D., Boonton; George Scheller, M.D., Millburn.

Trustee—1 year: Ogden B. Carter, M.D., South Orange.

Custodial Committee—Berthold T. D. Schwarz, M.D., Herbert A. Schulte, M.D., A. Russell Sherman, M.D., Montclair.

Drs. E. Z. Hawkes and Elbert Sherman resigned as trustees after serving ably and well for many, many years. The members present were unanimous in according them a vote of thanks and commendation for their services. Dr. Herbert M. Ill resigned as Secretary after serving efficiently and well for several years in this office.

This is the 75th year in the history of the Society and when a member dies, the others are assessed $1.00. The widow of the deceased member, as soon as proof of death is filed, is immediately given a check for 80 per cent of the assessment which now approximates $575. The annual total assessment has rarely exceeded $15, and simlar coverage through commercial companies would entail a cost of about $40 per year. In addition to the immediate benefit widows or orphans in need are granted various sums each year to help them with their financial burdens. This money comes from the income of the Permanent Fund which now amounts to slightly more than $100,000. All physicians in New Jersey who are not already members are urged to join—a letter to the secretary will bring an application blank.

J. W. GARDAM, M.D.

Secretary

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Drugs. By Harry Beckman, M.D. Philadelphia 1958. Saunders. Pp. 728. ($15.00)

The last decade has seen an upsurge of interest in pharmacology. New drugs for old diseases have brought new hope to all of us. So rapid has been the advance that a pharmacology book ten years old is almost as obsolete as a 1900 pharmacopeia. Dr. Beckman here gives us the first 1958 book on drugs. The text includes the standard approaeh to pharmacology—source of each drug, fate in body, how administered, clinical use, dosage, side-effects, contra-indications and so on. But it includes much more. There is a ready-reference table of drugs for infectious diseases, printed in the end-papers. There is an unusual section of the "pharmacology of diagnosis." There is a unique chapter on the predictability of drug action. The general arrangement is by physiology rather than by drugs. For instance, "the pharmacology of blood vessels" is one chapter; "drugs that depress skeletal muscles" is another.

Dr. Beckman writes in a vigorous, highly-personal, readable, dramatic, first-person singular style. He is slangy and breezy where that is appropriate. He is proud of his profession and writes as if pharmacology were fun.

ULYSSES M. FRANK, M.D.

A Therapy for Anxiety Tension Reactions. By Drs. G. B. Haugen, H. H. Dixon and H. A. Dickel. New York, 1958. Macmillan. Pp. 110. ($3.50)

The thesis here is that peripheral muscular tension causes anxiety rather than (as most psychiatrists believe) *vice versa*. Instead of finding out what emotional factors lurk behind the anxiety, the authors teach the patient Jacobson's method of muscle relaxation. Judging from the case reports here cited, the doctors talk a lot and the patients say very little. In fact the authors warn against letting the patient tell "what he thinks is important and how it bothers him and how he thinks it all began." Indeed, the authors believe that a doctor who lets a patient ventilate "does so largely because the doctor is baffled and hopes that maybe, in the welter of words, he can catch on to something." Although the book seems to be a revolt against the speculative over-theorizing of psychodynamics, the authors confess in the foreword that their hypothesis "is based largely on armchair speculation" and that they are unable to offer any proofs to support it.

It is hard to find what you want because the book has no index.

HERBERT BOEHM, M.D.

NOTE TO MEMBERS

In previous years the annual reports were published prior to the annual meeting and the transactions were issued as a supplement to THE JOURNAL in the fall. This year the annual reports and transactions are bound together in this issue of THE JOURNAL.

The action taken by the House of Delegates on each annual report is indicated in bold face type at the end of the report. The page numbers refer to the reference committee reports, which start on page 394. Correspondingly in the reference committee reports you will find the citation of the page number of each document to which the report refers.

The other activities of the annual meeting will be published periodically in THE JOURNAL and will be identified in the table of contents of each issue in which they appear, as well as in the index of the year.

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192nd ANNUAL MEETING OF
THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

MAY 17 - 21, 1958

President

(Reference Committee "A")

ALBERT B. KUMP, M.D., Bridgeton

(Deceased—April 18, 1958)

In my mind this year will stand out as the year of Golden Awards. The presidency of The Medical Society of New Jersey was a golden award to me, which came as a climactic compensation, over and above the satisfactions and rewards that have been mine across the years in consequence of my membership in and service to The Medical Society of New Jersey. So many and vital are the needs of our profession and of our country today, that no efforts which as individuals we make can be too great. Our sense of satisfaction grows with the measure of our giving, and our eagerness to serve increases with our awareness of all that must be done, and with our perception of the generous spirit with which so many of our colleagues and fellow-citizens are laboring with us.

The Golden Merit Awards I shall likewise fondly remember. No truer satisfaction was mine than to be privileged to have a part in the recognition and commendation of those men and women of The Medical Society of New Jersey who have served their profession for half a century or more. As President of The Medical Society of New Jersey, it was my happiness personally to present the plaques to a great many recipients and to share with them some small part of their accomplishments and joy of recognition.

The organization meeting of the Board of Trustees was held during the annual meeting in Atlantic City. Carl N. Ware, M.D., was elected Chairman of the Board of Trustees. It was decided that the Board should meet each month in an effort to expedite handling of material coming before it. With few exceptions the meetings were so held. The attendance at all Board meetings was excellent, and the burden of presidential duties was greatly lightened because of the able judgment and unstinted efforts of those serving as trustees.

An ad hoc Committee on Asian Influenza was established in order to recommend views regarding the priorities for distribution of the vaccine. This was accomplished in close cooperation with the New Jersey Department of Health. In addition the committee disseminated information to the physicians of the State relative to dosage of vaccine and the character of the disease itself.

For a number of years the specialty groups of pathologists and radiologists have been asking assistance of our Society in their attempts to attain satisfactory recognition, and to improve their relationships with hospitals, and with the Blue Cross and Blue Shield Plans. Consequently, representatives of The Medical Society of New Jersey, in conjunction with representatives of the pathologists, radiologists, the New Jersey Hospital Association, the Blue Cross and Blue Shield Plans, met as a conference committee seeking to establish "Principles of Approach to Specialty Services." Several meetings have been held and a great amount of material submitted. The problems have not been solved, but the approach has been established which ultimately will re-

solve the problems of those specialty groups. It is recommended that this committee be continued.

As my term of office draws to a close, I am conscious of a deep feeling of joy at having served. The willingness of those appointed to committees, the cooperation of the members of the Board of Trustees, the able assistance and guidance of the Executive Officer, the Administrative Secretary, and the entire staff, have made possible the rounding out of a delightful presidential year.

Approved (page 394)

Secretary

(Reference Committee "A")

Marcus H. Greifinger, M.D., Newark

The office of Secretary each year deals with an increasing volume of routine matters — correspondence, telephone inquiries, and completion of questionnaires received from many sources.

In addition, the Secretary has attended the Annual Meeting of the American Medical Association in New York, and the mid-winter meeting in Philadelphia, as well as the meetings of the Board of Trustees, and the committees of which he is chairman, member, or advisor.

MEMBERSHIP

(As of December 31, 1957)

Active-Paid	5,715
Exempt	237
Total Active	5,952
Associate	263
New and reinstated members	280
Members deceased	67
Transfers in state	19
Resignation and transfers out-of-state	38
State Emeritus	120
State Honorary	4
Members dropped for non-payment of dues	58
A.M.A. Members	5,484

A.M.A. MEMBERSHIP

As a natural consequence of the membership growth of The Medical Society of New Jersey, each year New Jersey membership in the A.M.A. increases. Our delegates to the A.M.A. continue to be six in number, based on the allocation of one delegate per 1,000 members or fraction thereof.

MEMBERSHIP DIRECTORY

The 1957-58 Membership Directory, the third issue of the publication, was mailed the first week in November, 1957. Listings include all members reported to the executive offices as of June 1, 1957.

We request that county treasurers make a special effort to report all members in good standing to the executive offices by the deadline date of June 1. Thus, when a new directory is in publication, physicians elected to membership immediately prior to the time copy is sent to the printer, may have their listings included.

A small portion of the membership fails to return completed questionnaires or corrected listings. However, this group seems to diminish with the publication of each successive edition.

Following is a cost analysis of the 1957-58 Membership Directory, based upon current figures:

Cost of publication—6,800 copies		$12,311.55
Reserve from 1955 Directory	$ 464.42	
Receipts: Sales to membership hospitals, and outside agencies	3,443.90	3,908.32
		$ 8,403.23

Net annual cost per member—71 cents

Distribution:

To active members (no charge)	5,868	
Complimentary and staff	43	
Sales	688	
Total		6,599
On hand		201

Approved (page 395)

Treasurer

(Reference Committee "B")

RUDOLPH C. SCHRETZMANN, M.D., Bergenfield

As the fiscal year does not close until May 31, 1958, a complete annual report cannot be submitted at this time. An interim report covering the accounts from June 1, 1957, through April 30, 1958, is presented below:

BALANCE SHEET — APRIL 16, 1958

ASSETS

Cash:		
First Mechanics National Bank of Trenton:		
General Checking Account	$180,342.58	
Executive Office Revolving Account	6,989.40	$187,331.98
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	11,403.53	
Howard Savings Institution, Newark	11,478.00	
Morris County Savings Bank, Morristown	929.64	
Montclair Savings Bank, Montclair	10,925.76	
Plainfield Trust Company, Plainfield	5,150.50	39,887.43
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,932.39	
Roma Savings and Loan, Trenton	10,755.93	51,688.32
Total Cash		$278,907.73
Accounts Receivable		9,895.70
Inventory Maternal Welfare Record Books, at cost (contra)		2,346.51
Investments—U. S. Savings Bonds		27,500.00
Land, Buildings and Equipment (contra)		130,435.98
Deferred Expense		40.00
Total Assets		$449,125.92

LIABILITIES, RESERVES AND SURPLUS

Employees' Payroll Deductions	$ 814.51
A.M.A. Dues Payable	25.00
Assessments Collected, Applicable to 1958-59	127,048.25
House Committee Reserve	829.00
Annual Meeting Reserve	23,246.08
A.M.A. Dues Collection Reserve	1,455.74
Membership Directory Reserve	4,025.02
Journal Reserve	5,993.54
Land, Buildings and Equipment Reserve (contra)	130,435.98
Maternal Welfare Record Books Reserve (contra)	2 346.51
Unexpended Budget Accounts, 1957-58 fiscal year	54,626.24
Surplus	98,280.05
Total Liabilities, Reserves and Surplus	$449,125.92

MEDICAL STUDENT LOAN FUND

Cash	$ 9,069.06
Notes Receivable	4,650.00
Investments—U.S. Savings Bonds	8,500.00
Total	$ 22,219.06

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1957-58

JUNE 1, 1957 — APRIL 16, 1958

RECEIPTS

Cash on Hand, June 1, 1957				$190,166.83
Assessments:	AMA DUES	STATE DUES	TOTAL	
Atlantic County	$ 3,700.00	$ 5,910.00	$ 9,610.00	
Bergen County	12,375.00	22,890.00	35,265.00	
Burlington County	2,175.00	3,520.00	5,695.00	
Camden County	7,550.00	12,425.00	19,975.00	
Cape May County	900.00	1,520.00	2,420.00	
Cumberland County	1,725.00	3,070.00	4,795.00	
Essex County	30,725.00	53,693.75	84,418.75	
Gloucester County	1,650.00	2,720.00	4,370.00	
Hudson County	11,900.00	20,585.00	32,485.00	
Hunterdon County	1,025.00	1,640.00	2,665.00	
Mercer County	8,362.50	13,358.25	21,720.75	
Middlesex County	6,900.00	11,065.00	17,965.00	
Monmouth County	5,550.00	10,855.00	16,405.00	
Morris County	5,400.00	8,805.00	14,205.00	
Ocean County	1,425.00	2,330.00	3,755.00	
Passaic County	10,562.50	20,561.25	31,123.75	
Salem County	1,200.00	1,920.00	3,120.00	
Somerset County	2,025.00	3,410.00	5,435.00	
Sussex County	975.00	1,640.00	2,615.00	
Union County	12,397.50	19,790.00	32,187.50	
Warren County	875.00	1,480.00	2,355.00	
Total Assessments	$129,397.50	$223,188.25	$352,585.75	
A.M.A. Dues Refunds			125.00	
Journal Advertising, net			42,286.75	
Annual Meeting Exhibits			17,006.25	
Interest			3,609.11	
Sale of Maternal Welfare Books			925.10	
Rents			669.63	
Payroll Deductions			814.51	
Refunds of Budget Expenses			1,340.50	
Janitorial Services			25.00	
A.M.A. Dues Collection			1,322.50	
Membership Directory			3,639.30	
Pension Plan Refund			1,155.06	
Dues Assessments from Prior Year			30.00	
Accounts Receivable Collected			268.53	
Total Receipts				$425,802.99
Total				$615,969.82

DISBURSEMENTS

Budget Accounts:		
A-1	Executive Salaries	$ 39,426.65
A-2	Executive Office Salaries	28,116.21
A-3	Executive Office Expenses	2,073.90
A-4	Executive Office Travel	770.66
A-5	House Maintenance	11,326.16
A-6	Treasurer	2,123.67
A-7	Finance and Budget	34.24
A-8	Secretary	2,555.07
A-9	Payroll Taxes	1,496.33
A-10	Insurance	1,527.80
B-2	Journal Office Expenses	364.12
C-1	Welfare Committee	508.23
C-2	Legislative Committee	3,560.57
C-3	Public Health Committee	889.28
C-4	Public Relations Committee	4,523.57
C-5	Medical Practice Committee	448.25
D-1	President and Other Officers	904.45
D-2	A.M.A. Delegates	7,249.19
D-3	Woman's Auxiliary	5,134.32
D-6	Membership, Directory, Physicians Placement	12,604.71
D-7	Emergency Medical Service, Civil Defense	10.00
D-8	American Medical Education Foundation	10,000.00

D-10	Blood Bank Commission	200.00	
D-11	Medical Defense and Insurance	61.50	
E-1	Board of Trustees	1,085.14	
E-2	Contingent	2,349.52	
E-3	Judicial Council	427.90	
E-4	Legal Counsel	3,251.32	
	Total Budget Accounts		$143,022.76
	Accounts Payable, May 31, 1957		9,045.88
	Journal Publication		42,565.41
	Annual Meeting		1,751.98
	Journal Commissions		2,575.44
	Janitorial Services		55.00
	A.M.A. Dues Collection		248.75
	Assessments Refunded		738.75
	A.M.A. Dues		129,772.50
	House Committee Reserve		1,820.41
	Budget Expenses for 1956-57		425.21
	Transfer to Medical Student Loan Fund		5,000.00
	Deferred Expense		40.00
	Total Disbursements		$337,062.09
	General Cash Balance, April 16, 1958		278,907.73
	Total		$615,969.82

Approved (page 396)

Board of Trustees

CARL N. WARE, M.D., Chairman, Shiloh

(Reference Committee "A")

The report of the Board of Trustees can only highlight the Board's activities of the year—most of which have been reported in THE JOURNAL. The Society's business has made heavy demands upon the time of the Trustees. Seven meetings have already been held and one more is scheduled before the annual meeting.

I wish to record my appreciation to all the Board members. They have served loyally and diligently; and I commend the orderly work of the numerous committees. Their generous endeavors have greatly facilitated the conduct of the Society's business.

It will be noted from the following items that the majority of the Board's activities has been on specialized subjects, which are referred to other reference committees for consideration in connection with the main subjects to be considered by those reference committees.

Regularly the Board of Trustees has dealt with general matters brought to its attention—correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of reports and recommendations of the several standing and special committees, including the Welfare Committee, its sub and special committees; cooperation with the State Department of Health in public health programs, and with the State Department of Motor Vehicles on traffic safety.

MEDICAL-LEGAL TESTIMONY

Three items from the actions of the 1957 House of Delegates were referred to a special committee for study and consideration:

1. Workmen's Compensation Testimony—which would involve a study of testimony in compensation courts on a state-wide basis;

2. Cooperation with the Division of Workmen's Compensation, State Department of Labor and Industry, for the purpose of improving the quality of medical testimony;

3. Formulation of Codes of Standards of Practice governing lawyers and doctors.

The special committee consolidated the first

two items, and with the approval of the Board of Trustees the third item has been held in abeyance until the first two are completed.

Meetings have been held with the Commissioner of Labor and Industry and the Director and Deputy Director of the Division of Workmen's Compensation, at which needed improvement in Workmen's Compensation medical testimony was discussed. Further meetings with representatives of the department and the division are planned to work out some method for making this improvement.

Approved (page 394)

SHORT-TERM INVESTMENTS

(Reference Committee "B")

Reference Committee "B" last year recommended that the Board of Trustees consider the advisability of short term investments, if and when the checking account justifies that procedure.

The Board of Trustees authorized the Treasurer to transfer to investments a portion of surplus funds, when there are such funds, in 30, 60, or 90 day United States Treasury Bills.

Approved. Reference committee recommendation that the Treasurer continue to explore the advisability of short-term investments—Approved (page 396)

MEDICARE PROGRAM

(Reference Committee "C")

Perhaps one of our busiest groups has been a small special committee appointed by the Board of Trustees to deal with problems arising out of the Medicare program. This committee has met frequently to consider disputed claims, supplemental agreements to the contract, and more recently, a revision of the fee schedule. With regard to the latter, the committee sought the assistance of the numerous specialty societies within the state, requesting lists of suggested fees for their respective services. The week following the close of the annual meeting the committee will go to Washington for a two day conference with government officials for renegotiation of the New Jersey contract and fee schedule.

The Special Committee on the Medicare Program has worked long and diligently in behalf of the members of The Medical Society of New Jersey, and deserves much credit for its achievements.

Approved (page 397)

HOSPITAL MEDICAL SERVICES

(Reference Committee "C")

Two resolutions on this subject from several component societies, approved in principle by the 1957 House of Delegates, called for deletion of medical services from Blue Cross and inclusion in Blue Shield. These were referred to the Conference on Principles of Approach to Specialty Services, and have been considered in the conference proceedings. A progress report of the conference has been referred to Reference Committee "E".

No action (page 397)

MEDICAL-SURGICAL PLAN

(Reference Committee "C")

1. Contract Inequities

A resolution calling for policy changes in Medical-Surgical Plan was approved in principle by the 1957 House of Delegates. Referred to the Permanent Committee on Blue Shield for study, the committee reported: (1) Cash benefits derived from insurance are not considered within the legal classification of "income." Therefore proceeds of an insurance benefit would not affect the income status of a subscriber with respect to his eligibility for "service benefits." (2) With respect to payment in cases where the patient has multiple non-profit medical-surgical coverage other than duplicate contracts within the same state, the Plan shall not be liable for payment "For services, otherwise hereunder, to the extent thereof that payment or reimbursement therefor is eligible under any non-profit hospital service plan and/or non-profit medical and/or non-profit surgical service plan, other than under this Contract." (MSP Subscription Contract, Section V(7)) (3) Regarding third party liability actions, it was the consensus of the committee that it would be better from the standpoint of the medical profession itself for the Plan to continue to make payment in third party liability cases under present contract provisions. It is better to receive the Plan's scheduled payment for professional services in each such case than to rely on the contingent possibility of a larger payment in perhaps 10 to 20 per cent of such cases through the public liability action which might take years to settle. (4) With respect to benefits, when necessary operative and non-operative care is rendered by one or more physicians, payment is made to the extent as defined in

the contract. (5) Relative to the request for an increase in the schedule of fees, the entire schedule is under review for adjustment of fees where indicated.

The report of the committee was approved, copies were sent to all component societies, and it was published in the January 1958 JOURNAL, page 42.

Approved. Recommendation of House of Delegates that legal counsel of The Medical Society of New Jersey be requested for opinion on items relating to multiple medical-surgical type coverage, third-party liability, and income classification with respect to recommending to the Blue Shield Board of Trustees the inclusion of these items in the present contract; if it is not possible, then these items are to be included in any type of contract subsequently issued—Approved (page 397)

2. Physician Lists

A resolution adopted by the 1957 House of Delegates requested Medical-Surgical Plan to revise its physician lists immediately, if feasible, to exclude osteopaths from the listing of doctors of medicine, and include osteopaths in a distinct and separate listing.

Medical-Surgical Plan last July notified the component societies and the State Society that the Department of Banking and Insurance had no objection to this procedure. The list of participating physicians as of December 1, 1957, separates the doctors of medicine and the doctors of osteopathy.

Approved (page 397)

3. Board of Trustees

The nominations of three new members to the Board of Trustees of Medical-Surgical Plan for 1957-58 were approved:

James H. Spencer, M.D., Newton
Robert G. Boyd, Morristown
Duane E. Minard, Jr., Newark

The following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for 1958-59 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Robert G. Boyd
Harry N. Comando, M.D.
Patrick H. Corrigan, M.D.
William F. Costello, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Joseph M. Keating, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Duane E. Minard, Jr.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
James H. Spencer, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

Approved (page 397)

4. Two Level Contract

The Board of Trustees was informed that the Department of Banking and Insurance, although opposed in 1955, was now more receptive to the idea of supplemental contracts with higher limits for income, premium, and benefit payments; and that it might be possible to get acceptance of the two level contract plan.

The Board reaffirmed its previous action of October 2, 1955: "That the Board approve the proposal of Medical-Surgical Plan to develop one or more supplemental policies in various income levels as rapidly as possible."

Approved (page 397)

5. Home Care Benefits

At the request of Medical-Surgical Plan, the Board reviewed a proposal made by interested union officials for inclusion of home care benefits in Hospital Service and Medical-Surgical insurance plans. It was the consensus of the Board that the proposal is not practicable at this time.

Approved (page 397)

6. Medical-Surgical Plan Policies

In conformity with the action of the 1957 House of Delegates, a special committee was appointed by the President to study the policies of Medical-Surgical Plan. The report of the committee, published in full on page 79 of the February JOURNAL, was approved by the Board and copies sent to all component societies. It stated in part:

> From an analysis of the resolution which formed the basis for the action of the House of Delegates and from the implications contained in the action establishing this committee, it was apparent that also imposed was an obligation to investigate and weigh expressions of dissatisfaction with Plan policies or practices originating with members of The Medical Society of New Jersey. As a means of insuring that the Com-

mittee might have full appreciation of members' attitudes of criticism or disapproval of the Plan, a request was published in the *Membership News Letter* urging all members to submit complaints, criticisms, and constructive suggestions to the committee. In all, four letters were received in response to this invitation.

Conclusions: It is inevitable that a program of such extensiveness and magnitude as the Medical-Surgical Plan—dynamically evolving as it is—should be beset by complexities and difficulties that produce some discontent and dissatisfaction. The discontent—as far as your committee could discern—is by no means "widespread among our members" as the House resolution alleges. By and large, the policies, procedures, and benefits of Medical-Surgical Plan are a source of real satisfaction to the majority of participating physicians. Non-participating physicians are uneasily critical of alleged discriminations that in large part are attributable to the status in relation to the Plan which, by their own choice, they prefer to maintain. By becoming participating physicians they could enjoy the direct payment of benefits which seems to be the accommodation which principally they seek.

Your committee is of the opinion that lack of understanding—on the part of subscribers and physicians alike—concerning the policies and procedures of Medical-Surgical Plan, is the basis for most of the complaints that arise.

Therefore your committee recommends: (1) That sustained and comprehensive educational efforts be directed to both subscribers and physicians, to inform them adequately of all aspects of the Plan's operations.

(2) To this end, in connection with bringing information to members of The Medical Society of New Jersey, it is recommended that this, or a similar committee, be continued by the Board of Trustees of The Medical Society of New Jersey, to serve as a clearinghouse for the dissemination of information. It would be a function of this committee to receive written questions and complaints concerning the Plan from our members, and to supply authoritative answers and responses after investigation and consultation. All information provided by such committee should be published for the enlightenment of the entire membership through a department established for that purpose in the *Membership News Letter* and other publications of the Society.

(3) The Medical-Surgical Plan committees of all component societies should be reactivated, to serve—at county level—in supplying information about the Plan and in reflecting to the state committee the attitudes and reactions of member-physicians. As necessary, the county committees could coordinate their efforts with those of the state committee and assist it in its efforts to appreciate all points of view, and to provide a complete informational service to both Medical-Surgical Plan and the members of The Medical Society of New Jersey.

Reference committee recommendation for amendment as follows: In (2) delete the wording "that this, or a similar committee, be continued by the Board of Trustees of The Medical Society of New Jersey, to" and substitute: "that the Permanent Committee on Blue Shield"—Approved

Reference committee recommendation for addition of the following: (4) The chairman or a member of each county Medical-Surgical Plan Committee meet with the Permanent Committee on Blue Shield in sufficient time prior to the annual meeting of the House of Delegates to discuss all unsolved problems and potential or possible resolutions applicable to the Medical-Surgical Plan—Approved

Approved as amended (page 397)

7. Chiropodists and Dentists

In 1953 an amendment to the enabling act made chiropodists eligible for payment for their services rendered within their scope of practice. Other groups are also seeking inclusion. In reply to a question raised by Medical-Surgical Plan as to whether payment should be made to chiropodists, or whether payment should be refused with the possibility of MSP facing a law suit, the Board took the following action: The Board of Trustees urgently requests the Trustees of Medical-Surgical Plan of New Jersey to continue the limitation of its payment of eligible benefits to persons holding full licenses to practice medicine in the State of New Jersey in the present contract and in all contracts to be issued in the future.

Approved (page 398)

MEDICAL SERVICE CORPORATIONS - PARTICIPATING PHYSICIANS

(Reference Committee "C")

As a result of a general solicitation of the membership by an out-of-state medical service corporation for participating physicians, several members inquired as to whether they should sign up as participating physicians.

After consideration and review of past actions, the following statement of policy was adopted to serve as a guide for New Jersey physicians: The Board of Trustees recommends to our members that they limit participation in non-profit service benefit medical insurance plans to those plans whose Boards are composed of majorities of physicians who have been approved by their State Medical Societies and whose contracts have provisions, schedules of benefits, and income limits which have been approved by the State Medical So-

ciety in the State in which the corporation is chartered.

Approved (page 398)

MEDICAL SERVICE ADMINISTRATION

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration for 1958-59 were approved by The Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Harry N. Comando, M.D.
William F. Costello, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 397)

FALSE COMPLAINTS

(Reference Committee "D")

The 1957 House of Delegates approved the report of the Special Committee on False Complaints which had recommended that the use of the countersuit, made possible by Chapter 122, laws of 1956, be established by Society policy, the expense of the same to be borne by The Medical Society of New Jersey at the request of the doctor or doctors involved in a suit under their professional liability policy; and the outlined publicity and conference program be followed. A special committee of the Board of Trustees was appointed to consider this recommendation.

It was the consensus of the special committee that this was not the time to start the action advocated by last year's committee and little interest is shown in the Medical Society's being the first to bring suit against someone who has unsuccessfully taken legal action against a doctor. It has not been demonstrated in the legal profession that such procedure has helped any lawyer so involved. The Society's counsel did not think it would do the medical profession any good to institute suit. Counsel stated that the statute does not give the medical profession any greater right than it has always had, and in his opinion the expenditure would not be warranted by the results obtained. By action of the Board of Trustees the matter was tabled.

Approved (page 399)

PRINCIPLES OF APPROACH TO SPECIALTY SERVICES

(Reference Committee "E")

The House of Delegates last year authorized the Board of Trustees to convoke a general meeting, or a series of meetings, of all interested groups, confronting around a conference table all the various representatives, so that all aspects of the problem could be openly explored, objections and refutations made and met, and solutions understood and agreed on by all concerned.

Five special conferences have been held. Representatives from The Medical Society of New Jersey were the President, presidential officers, and Chairman of the Board of Trustees. There were three representatives from each of the following organizations: New Jersey Society of Clinical Pathologists, Radiological Society of New Jersey, Hospital Service Plan of New Jersey, Medical-Surgical Plan of New Jersey, and the New Jersey Hospital Association.

While the problems have not been solved, the conference group definitely feels that progress has been made. A suggested uniform sample agreement between physicians and hospitals has been submitted by the pathologists, which is also acceptable to the radiologists. Representatives of the two specialty groups will meet with representatives of Blue Shield to discuss this agreement, after which The New Jersey Hospital Association will hold a meeting of its General Assembly for discussion of the overall proposals. Representatives of the Medical Society, radiologists, and pathologists will be invited to attend this meeting.

In its discussions, the conference group has also considered the two resolutions, approved by the 1957 House of Delegates, which call for exclusion of medical services from Blue Cross and their inclusion in Blue Shield.

Approved (page 401)

CORPORATE PRACTICE OF MEDICINE

(Reference Committee "E")

A resolution adopted last year requested that the Society take immediate and definite steps to prohibit the corporate practice of medicine in New Jersey by May, 1958. It was referred to the Subcommittee on Legislation.

According to the report of the Society's legislative analyst, which was approved by the

subcommittee, the corporate practice of medicine is, in effect, already prohibited in New Jersey. The subcommittee therefore concluded that there was no need to take "immediate and definite steps." The conclusion of the subcommittee and the report of the legislative analyst were approved by the Board of Trustees.

The action of the Board of Trustees, and the report of the legislative analyst (reprinted below), were sent to all component societies.

> "Corporate practice of medicine" is prohibited in New Jersey. The issue as it has been presented to the Medical Society is not truly a question of "corporate practice of medicine," which is prohibited by law and fact (R.S. 45:9-22), since only a person licensed to practice medicine and surgery may so practice in this State, and a corporation may not become so licensed, but rather the practice of hospitals' engaging the services of radiologists, pathologists, resident physicians, and others licensed to practice medicine and surgery on a salary basis. This practice is not prohibited by our statutes.

Approved (page 401)

ENGLISH AS A FACTOR FOR MEDICAL LICENSURE

(Reference Committee "E")

This resolution, approved by the 1957 House of Delegates, called for legislation to require every applicant for a license to practice medicine in New Jersey to demonstrate an adequate command of the English language. The resolution has been under study in the Subcommittee on Legislation. In answer to a question by the subcommittee as to whether the existence and operation of the newly formed "Educational Council for Foreign Medical Graduates" will, in the view of the Bergen County Medical Society (sponsors of the resolution), satisfactorily exercise the function of screening foreign medical graduates to make certain of their competence in the comprehension and use of the English language, representatives of the Bergen County Medical Society declared: "We are willing to let this resolution die provided that New Jersey is participating in this program, and that those applying for licensure in New Jersey will be screened by this organization." The New Jersey State Board of Medical Examiners has assured the subcommittee that New Jersey is participating in the program and will in the future report upon its effectiveness.

Approved (page 401)

DOCTORS OF OSTEOPATHY

(Reference Committee "E")

Approved by the 1957 House of Delegates was a resolution from the Bergen County Medical Society calling for legislation to regulate the use of the M.D. degree. It was referred to the Subcommittee on Legislation for study and report. Legislation such as advocated would require amending and supplementing the Medical Practice Act.

The matter is presently under discussion between the Society's legislative analyst and the counsel to the State Board of Medical Examiners.

Approved (page 401)

INTRAVENOUS MEDICATIONS

(Reference Committee "E")

In response to a request from the New Jersey State Nurses' Association for a policy decision which would afford nurses protection when they are called upon (as they now sometimes are, especially in hospitals) to administer intravenous medications, the Board's opinion has been referred to the Subcommittee on Legislation for study as to what might be necessary to effect a change in the Medical Practice Act to enable nurses to give such medications.

Approved (page 401)

VETERANS ADMINISTRATION CONTRACT

(Reference Committee "E")

At the request of the Veterans Administration in Washington, the contracted fee schedule was transposed to a new format insofar as numerical codes and descriptions of procedures were concerned. In addition, a table of comparative fees for all coded items was prepared from various fee schedules.

Subsequently the Veterans Administration suggested that a new schedule of fees be established wherein only the more commonly authorized services would be listed, thus eliminating a great portion of the current fee schedule for items never used.

A special committee met with representatives of the Veterans Administration in Newark, and a new schedule of fees was nego-

tiated. It includes all commonly authorized services, plus those services for which the Society has a negotiated fee higher than the fee indicated in the national guide. For any procedure not included, the Society has agreed to abide by the fee indicated in the national guide.

A resolution received from the Middlesex County Medical Society urged that the fees for office and home visits be increased from $3.00 and $4.00 to $4.00 and $5.00, respectively. The new schedule includes these higher fees.

Approved (page 401)

ASIAN INFLUENZA

(Reference Committee "E")

During the summer and early fall of 1957, considerable time was necessarily given to the Asian Influenza epidemic. In cooperation with the State Department of Health a statement of suggested priorities for the administration of vaccine was prepared and issued. A special ad hoc committee was appointed with power to promulgate decisions as needed, and to have access to anyone in this Society or anywhere else for advice. Statements and policies concerning Asian Influenza and the vaccine were published and distributed to the membership as need therefor was indicated.

Approved (page 401)

NURSING ASSISTANTS

(Reference Committee "E")

The Union County resolution, approved by the House of Delegates last year, called for the appointment of a special committee to confer with representatives of the State Department of Education and of the nursing profession to explore the possibility of establishing a program of secondary school training courses. A special committee was appointed to follow out the directive of the resolution.

The committee met with representatives of the State Department of Education who indicated their willingness to do anything possible, and stated they would support any plan agreed upon by the nurses and the Medical Society. At a meeting of the committee with representatives of the nursing profession, the nurses contended that there is no critical shortage of nurses in New Jersey, but that nurses are increasingly lost to service because of inadequate administrative policies and inadequate medical supervision. The nurses would not support any curtailment of curriculum in nurse training because it would hurt recruitment of student nurses through evolving a program of training that would be substandard. The committee considered many facts which may well lead to measures jointly sponsored by the nursing and medical professions that will improve the situation. Attention was called to the fact that already work is being done to present nursing refresher courses as a means of encouraging and facilitating the return of trained nurses to patient care. Moreover, the recruitment and training of practical nurses is being stepped up throughout the state.

The above progress report of the special committee was approved by the Board of Trustees, and the committee was requested to continue its efforts.

Approved (page 401)

CLASSIFIED TELEPHONE DIRECTORY LISTINGS

(Reference Committee "E")

In response to the resolution adopted by the 1957 House of Delegates, requesting special classified listings in telephone directories for physicians, the New Jersey Bell Telephone Company indicated it could not comply with the resolution. The letter stated " . . . that subdivisions or qualifying terms would interfere with the continuity of listings and thus confuse directory consultants . . . it has been our aim to keep the wording in the headings simple . . . Experience has borne out the wisdom of this decision and confirms the principle that a classified telephone directory best serves its public when the headings under the businesses and professions listed are worded in a general manner in order to be applicable to as many individuals as possible. This facilitates reference by providing more complete representations under a single heading than would otherwise be possible."

A copy of this reply was sent to each component society for its information.

Approved. Reference Committee recommendation that the sponsors of the original resolution consider the possibility of a resolution authorizing each county society to purchase space in the classified section of the telephone directory for the listing of names of members of the county medical society in each community——Approved (page 401)

BLOOD BANK COMMISSION

(Reference Committee "E")

A report from the New Jersey Blood Bank Commission—designated two years ago as the Society's official agent in all matters relating to blood supply, et cetera—recommended that The Medical Society of New Jersey initiate legislation for the control of blood banks and blood bank practice within the State of New Jersey. The commission stated that such legislation should reflect the fact that blood banking is a branch of the practice of medicine and shall be practiced only by a physician duly licensed in this state; and should also include requirements which would give evidence of adequate training of physicians who direct blood banks in New Jersey. Attention was directed to the fact that legislation has been enacted and is being enforced in the City of Newark which regulates all aspects of blood bank operation and is recommended by the New Jersey Blood Bank Commission. The report also outlined the activities of the commission during the past year—continuance of an educational program for pathologists, technologists, and other workers in the field of blood, blood banking, and blood transfusion in cooperation with the State Department of Health and Rutgers University; assisting component societies in specific problems; conduct of a voluntary blood sampling and evaluation program in cooperation with the State Department of Health.

The Board accepted the report of the commission and referred the recommendation concerning legislation to the Subcommittee on Legislation for study and report.

Approved (page 401)

EXAMINATION OF HOSPITAL RECORDS

(Reference Committee "E")

The resolution on the examination of hospital records, introduced at the final session of the 1957 House of Delegates, was referred to the Subcommittee on Legislation. The following report of the Society's legislative analyst was approved by the subcommittee and referred to the Board of Trustees for its information and decision concerning possible action. The Board approved the action of the subcommittee and the report of the legislative analyst, and directed that no further action be taken on the matter. Copies of the Board of Trustees' action and the report of the legislative analyst were sent to all component societies.

The resolution advocates amendment of the law permitting any person against whom a claim is asserted for personal injuries, or his agent, to examine the records of a hospital concerning the claimant. The resolution recommends amending the law to permit inspection of such records only upon "consent in writing" of the claimant. Such an amendment would in effect repeal existing law. All a claimant need do is to refuse to grant consent in writing and the person sued or his agent would be obliged, as was true before existing law was enacted, to obtain an order of the court permitting review of hospital records. Experience has proved that the Legislature will repeal a law only if it appears that injustice is perpetrated because of that law.

The question arises: What is the injustice here? The whereas clauses of the aforementioned resolution conclude:

(a) "Hospital records are indiscriminately examined by unauthorized persons."

Any examination however cursory if performed by an unauthorized person would be improper. Should this fact warrant repeal of the law or would an amendment to the law subjecting such person to fine and imprisonment as a disorderly person be the proper solution to the problem?

(b) "It is imperative for the protection of the patients that this abuse be stopped."

What is the specific danger to the patient from review of his hospital records which should be protected? Is it the common law that a man's person shall be inviolate from the prying eye of his neighbor? Is this such as warrants repeal of a law in effect since 1945, or may the problem be resolved by less drastic legislation as suggested in (a) above? Is the problem one which may be caused by lax hospital administration? Should amendments, as might be drafted, hold the hospital responsible for permitting review of hospital records by "unauthorized persons?"

I do not believe the Legislature would be favorably disposed to the amendment advocated by the Middlesex County Medical Society. Insurance lobbies can be expected to fight an amendment as proposed by said Society.

Reference committee recommendation that, in view of the previous action of the House on the resolution from the Middlesex County Medical Society on this subject, further consideration of the resolution be given by the Board of Trustees—Approved (page 401)

Judicial Council

(Reference Committee "A")

D. F. Featherston, M.D., Chairman, Asbury Park

Apart from its work as an appellate tribunal considering matters originally dealt with by county judicial committees, the Judicial Council has the responsibility of supervising, directing, and keeping records of all complaints dealt with by county judicial committees as matters of original jurisdiction. To accomplish this, the Council, through the cooperation of county judicial committees, receives reports of all cases accepted for adjudication by county judicial committees, and of the dispositions made of them.

From the official files of the Judicial Council, we present the following resume of the operations of the Judicial Council and of county judicial committees for the year now ending March 31, 1958:

By the Judicial Council:

Appeal Hearing before the A.M.A. Judicial Council	1
Appeal Hearings Held	9
Opinions Rendered	3

1) Opinion concerning the ethical acceptability of a doctor's testifying on a contingency basis

2) Opinion concerning the ethical acceptability of a surgeon's paying a surgical assistant a portion of the fee received from an insurance carrier

3) Opinion concerning the ethics involved in adoption proceedings

(N.B.—For the information of the membership, these three opinions are presented in full as an appendix to this report.)

By County Judicial Committees:

Complaints reported as disposed of	51
Complaints still pending	11

The Judicial Council is continuing to emphasize to all judicial committees of component county societies that it is absolutely essential for the efficiency of the operation of the judicial mechanism that Report Forms A and B be promptly submitted to the Judicial Council in conjunction with all complaints referred to the county judicial committees. Only when such forms are regularly supplied can the Council be sure that it is cognizant of all the actions of county judicial committees, and only then can it properly exercise its supervisory responsibility for the entire judicial mechanism.

The following report of the Judicial Council of the American Medical Association—as abstracted from the proceedings of the A.M.A. House of Delegates at the clinical meeting in Philadelphia, December 3-6, 1957—is reprinted for the benefit of all:

"The speaker referred the report of the Judicial Council as printed in the Handbook of the House of Delegates (see the *Journal*, October 26, 1957, pages 1024-1025) to the Reference Committee on Amendments to the Constitution and Bylaws. The Reference Committee commended the report to the members of the House for serious study.

"It called attention to the fact that the 1957 edition of the 'Principles of Medical Ethics' was not intended to and does not abrogate any ethical principle of the 1955 edition, and endorsed the statement that if local societies fail to curtail unethical practices ethics lose their effectiveness. Failure on the part of the component society to demand respect for and adherence to the 'Principles' breeds contempt and disrespect for them. The committee also noted that the opinions and reports of the Council have been abstracted and annotated, and believes that this document should receive wide distribution since it will be of assistance to medical societies when called upon to resolve ethical questions within their own jurisdictions."

I cannot close this report without paying tribute to my fellows of the Judicial Council for the constancy and the efficiency with which they have fulfilled their responsibilities throughout the year. The Council meets regularly each month except during July and August, and its meetings regularly consume four or five hours. As Chairman of the Council I have never heard grudging comment from any member of the Council, and I have been profoundly impressed by the unselfish loyalty which the Councilors bring to all their efforts in behalf of The Medical Society of New Jersey. I am indebted to them for their work and for their inspiration, and I wholeheartedly

commend them for the approbation of this House. Likewise I commend our Legal Counsel and our Executive Officer, without whose advice and assistance it would be impossible for the Council efficiently to operate.

Opinion of The Judicial Council of The Medical Society of New Jersey Concerning the Ethical Acceptability of a Doctor's Testifying On a Contingency Basis

(Opinion officially adopted June 27, 1957)

The Council considered an inquiry submitted by a member in which he requested a ruling from The Medical Society of New Jersey as to whether or not it is unethical for an expert medical witness to agree to testify on a contingency basis.

The councilors discussed the question at some length and agreed unanimously that "it is unethical for a physician to testify on a contingency basis."

Opinion of The Judicial Council of The Medical Society of New Jersey Concerning the Ethical Acceptability of a Surgeon's Paying a Surgical Assistant a Portion of the Fee Received From an Insurance Carrier

(Opinion officially adopted June 27, 1957)

Referred by the Board of Trustees to the Judicial Council for consideration and reply was a letter from a doctor, acting as spokesman for the staff of a hospital, who said: "The average insurance company sends a surgeon the stated fee of the insurance policy and will only issue one check to the operating surgeon. Is it ethical procedure for the operating surgeon to allow his assistant the same fees as allowed by the Medical-Surgical Plan?" The doctor continued: "I would request that you obtain for me a ruling from the State Medical Society of New Jersey in reference to this problem that has been placed before us."

The Council pointed out that the fundamental question concerning the ethics involved in a division of surgical fees has been dealt with in an earlier opinion. The Council therefore directed that the portion of that opinion which is relevant to the doctor's request be supplied for his information. It follows:

> " . . . It is the opinion of the Judicial Council that any secret division of a fee between two physicians is unethical, and should be considered as such whether the fee is distributed by an individual for services rendered or by any insurance company or agency designated for the purpose of such distribution or payment.
>
> "Attention is called to the fact that in this unethical practice of 'fee splitting' the essential note is that the terms of the division of fees and the actual division thereof are the results of a secret or clandestine agreement entered into by the participating physicians without the knowledge and consent of the patient. In condemning such procedure as unethical the decision of the Judicial Council of The Medical Society of New Jersey is in conformity with opinions already rendered by the Judicial Council of the American College of Surgeons ('Certain Unethical Practices in Surgery', April 15, 1952).
>
> "In rendering this decision regarding the unethical character of 'fee splitting,' in the sense above defined, the Judicial Council of The Medical Society of New Jersey takes cognizance of the fact that separate payment of fees to two physicians both of whom actively participated in the care of the patient and both of whom are being openly compensated with the knowledge and approval of the patient, for services rendered, is not involved.
>
> "The Judicial Council of the American Medical Association commenting upon Section 5, Article VI of the Principles of Medical Ethics, has this to say: 'The Council interprets this (Section 5, Article VI) to mean that the physician who takes over for treatment from another physician should render a bill direct to the patient for such treatment. If this happens to be a surgical case and the doctor referring the patient assists in the operation, gives the anesthetic, or participates in any way in the treatment of the patient, the doctor so participating should render his own bill direct to the patient, and it should not be put on the surgeon's bill . . . The Judicial Council has held many times that when a surgeon renders a bill for his fee it should not include bills from colleagues who act as assistants or anesthetists, but these colleagues should render their own bills.'
>
> "Likewise, Dr. Paul R. Hawley, Director of the American College of Surgeons, in a letter dated May 21, 1952, declares: 'This College recognizes the contribution of others than the operating surgeon to the case of surgical patients, and the fact that such must be compensated. However, the College believes that compensation should be fixed in accordance with the contribution and not by a percentage arrangement . . . It may be administratively impossible to determine the proper division of the fee in each individual case. However, a schedule for the division can be drawn up which will set the average in each category. Massachusetts Medical Service has such a schedule.'
>
> "The Judicial Council of The Medical Society of New Jersey therefore concludes that 'fee splitting', applied in the commonly accepted and opprobrious sense, is a dishonest and secret procedure contrary to the ethical principles of the medical profession. It nevertheless acknowledges that the possibility exists of an ethical assign-

ment of payment to two physicians who share in the care and treatment of a given patient, when the services are rendered and the payment is made with the knowledge and approval of the patient and when such payment is demonstrably in proportion to the worth of the services rendered by the physicians involved." (From an opinion rendered by the Judicial Council concerning the ethical aspects of the division of fees, under date of December 28, 1952.)

It was the unanimous verdict of the councilors that the foregoing opinion governs in this instance. The councilors suggested the possibility of utilizing other means to deal with the problem. One suggestion was to refer the whole matter to the committee of this Society which meets with a similar committee of the Health Insurance Council to make overtures to the Council to see if it might be possible for the insurance company to accept separate bills and to issue separate checks in payment for services rendered, with a notification to the patient of the division of the compensation.

Opinion of The Judicial Council of The Medical Society of New Jersey Concerning the Ethics Involved in Adoption Proceedings

(Opinion officially adopted January 5, 1958)

Referred by the Board of Trustees—under date of December 23, 1957—to the Council "for consideration and reply," was a request from the Mercer County Component Medical Society ' for an opinion concerning doctors involved in adoption proceedings—specifically as to the ethics of a physician's giving background medical history to the Children's Home Society without the family's consent."

It is the unanimous opinion of the Judicial Council that this question is not one of ethics but rather involves a matter which has already been dealt with in an article on the disclosure of medical information written by Society's legal counsel, which appeared in the March, 1957 issue of THE JOURNAL of The Medical Society of New Jersey, as follows:

A question has been raised concerning the disclosure of confidential medical information to non-medical personnel. The basis for the question is the increasing practice of people in industry and other groups to ask for the diagnosis of illness of absentee personnel and to receive and process such information through office personnel with the possible result of embarrassment or harm to the patient through that or further dissemination of such information.

The solution to the problem is not an easy one It cannot properly be resolved, in view of the interpretation of our laws, by a blanket agreement or directive not to reveal patient information to any other than medical personnel. Nor is it fair to impose upon the inquirer in every case the burden of obtaining written permission of the patient as a prerequisite to disclosure.

Although at common law communications between physician and patient were not privileged, a majority of our states (30 plus District of Columbia) have passed statutes of one kind or another granting such a privilege. New Jersey is not one of those states. It adheres to the more progressive, even though minority, view that the public welfare outweighs the right of the individual patient to have his communications to physicians free from disclosure.

There does exist in New Jersey, however, a right of privacy. This is the right of an individual to be free from unwarranted publicity; to be let alone, to be protected from any wrongful intrusion into his private life, which would outrage or cause mental suffering, shame, or humiliation to a person of ordinary sensibilities. This right of privacy is limited, and is not always superior to the right of the public, but must be construed in the light of the individual's relation to the community of which he is a member. For example, the duty of witnesses to give testimony in matters vital to public interest is paramount to any personal right of privacy. And in balancing the private interest with the public interest, the weight favors the public, provided there is no abuse of power.

In New Jersey there is almost no law pertaining to the question of how far a physician may go in disclosing to third persons details concerning his patient without invading the individual's right of privacy. However, some basis for interpretation is gained by the decisions of our sister states which have statutes making the physician-patient relationship a confidential one. Even in those states a physician may be justified in disclosing medical details where it is necessary to prevent the spread of contagious disease; where it is necessary for the protection of one whom it is reasonable to suppose might otherwise be exposed, and, where in each of the above cases it is done in good faith, without malice, and the grounds for the diagnosis are reasonable. It would appear to follow logically that our right, as well as our obligation to disclose, is at least as great as those states regulated by specific privilege statutes.

The disclosure of information to non-medical personnel therefore requires an examination of the facts in each case on their individual merits based upon the considerations herein set out.

Approved. Recommendation of reference committee that membership peruse above opinions—Approved (page 395)

Executive Officer

(Reference Committee "A")

Richard I. Nevin, Trenton

Confronted by a deadline which cannot be deferred, I am writing this report on the night of the day on which Dr. Kump died. The darkness of night is about me, but it is the shadows of sorrow that oppress me—as they oppress all of us of The Medical Society of New Jersey who knew and loved Albert Barker Kump.

Customarily, in reporting to the House of Delegates, I strive to sum up my impression of the significance of the year. In his Presidential Report—which he composed even while Death, as it were, was plucking at his sleeve—Dr. Kump said of 1957-1958, "It has been a year of golden awards."

He had in mind the citations bestowed by the Society upon those members who have held their degrees and served as doctors of medicine for fifty years or more. But perhaps —with unconscious wisdom and preternatural discernment—he epitomized for all of us the character of the year of his presidency. In terms of inspiration and spiritual profit, the year of the presidency of Dr. Kump has truly been the year of golden awards—the year in which we of The Medical Society of New Jersey enjoyed the benefaction of grace, the exemplifications of integrity, fortitude, and constancy which shone forth in the simple heroism with which he unflinchingly rendered the last full measure of devotion.

In my heart I am certain that, from the time at which he took office, Dr. Kump knew that the likelihood of his living to complete his term was very slight. Yet, such was the valor of his spirit, such the uncompromising character of his sense of responsibility and duty, that never did he make the least concession to his condition. Instead, with disciplined intensity he held himself to his work for his colleagues and his fellowmen, until his body could no longer respond to the demands of his indomitable spirit.

This has been a year of great enrichment for The Medical Society of New Jersey—not only in terms of the services rendered to its aims and endeavors as an organization, but especially in terms of the good accruing to the souls of its members, in consequence of the example of virtue and of valor which its President supplied. He has shown us, with unmistakable impressiveness, how a good man lives . . . and dies.

It has also been a year of poignant and irreparable loss—of one the lamp of whose life has burned out, but the radiance of whose kindly and generous spirit will linger to exalt and encourage us as long as love remembers.

Like the years immediately preceding, this year has been one of intense activity and constantly accelerating tempo. This circumstance arises out of the fact that the world of medicine—both as an art and a science—is constantly expanding. New horizons are developing, new goals are emerging, new technics and treatments are evolving. In consequence new services are called for, and new demands are being made. In conjunction with them, new problems arise that call for ingenuity, patience, and industry to deal with them.

The services and benefits which medicine has to offer, by way of restoring or safeguarding health, are such that all citizens wish to enjoy them. But they are costly to provide, and what people want—even demand as a right—frequently exceeds their individual ability to pay for. This is true in regard to all the conveniences, services, and goods available in our time, but it poses an especially pressing problem in the field of medical care. There is a growing popular tendency to reason "What we cannot or will not pay for individually, we can finance collectively. What we cannot pay for, the Government can." So strong is the popular desire, so insistent the demand, that methods of gratifying it are contemplated and urged in disregard of the fact that they jeopardize our national economy and strength, and threaten to enslave medicine and its practitioners . . . all in the name of providing liberty and justice for all!

That is why the concerns and activities of our Society grow and intensify. That is why our committees are numerous, our contacts are many and growing, our meetings and conferences more numerous and protracted. We have two great purposes to serve: the improvement of the standards and quality of medical care, and the preservation of our form of government and our way of life.

Perhaps I can convey an appreciation of

the activity entailed by pointing out that whereas two years ago I reported that in the Executive Offices we handled some 165,000 pieces of mail, this year we estimate the volume to have been in excess of 190,000 pieces. My own activities may be accepted as indicative of the general pace which your officers are called upon to maintain. Since I last reported to this House, I find that—over and above my regular work of corresponding, advising, composing, editing, explaining, placating, and directing—I have participated in 171 meetings or conferences, filled fourteen speaking engagements, and made four trips out of state to conventions or special meetings.

The story is the same for all who serve The Medical Society of New Jersey. As Homer said of the heroes of Thermopylae, "Good men (and women), all!"

I think it only fair to point out that some of our committees are called upon to deal with matters more extensive and burdensome than others. Therefore, as deserving of even more than the average meed of praise, I wish this year to mention the Board of Trustees, the Committee on Revision of Constitution and Bylaws, the Committee on Medicare, the Conference Committee on the Principles of Approach to Specialty Services, and the Judicial Council.

From time to time we are asked for a summary of activities of The Medical Society of New Jersey. So that such a summary may be available for all, I am presenting as an addendum to this report my version of "The Medical Society of New Jersey In Action." I hope it may prove useful in outlining the work that in the Society we all share in, doing the big job that it is ours to do.

THE MEDICAL SOCIETY OF NEW JERSEY IN ACTION

The official business of The Medical Society of New Jersey can be considered under five headings: (1) Business centering about membership services and benefits; (2) business dealing with the official operations of the Society through its agents and agencies; (3) business deriving from the administration of Society concerns with reference to organized medicine; (4) business arising from the administration of matters with reference to associated and cooperating non-medical groups and associations; and (5) business dealing with the relations of doctors, individually and collectively, with the general public.

Routine operations under these headings include such matters as the following:

Group 1. Business centering about membership services and benefits:

1. Maintenance of official headquarters as a base for official operations of The Medical Society of New Jersey, including arrangements for meetings of official groups of the Society or approved medical organizations.

2. Maintenance of official lists of members, revised and corrected from week to week for accuracy.

3. Correlation of our official lists with those of county medical societies, on the one hand, and the American Medical Association, on the other.

4. Biennial preparation and distribution of the *Membership Directory*.

5. Preparation and publication of THE JOURNAL of The Medical Society of New Jersey, *Transactions of the House of Delegates*, and of the *Membership News Letter*.

6. Planning, organizing, and supervising all details of the Annual Meeting.

7. Operation of the Physicians Placement Service.

8. Administration of the Medical Student Loan Fund of The Medical Society of New Jersey.

9. Processing of inquiries and problems submitted by component societies, groups of doctors, or individual members.

10. Negotiating contracts, processing schedules, and fulfilling the obligations involved in the Veterans Administration and Medicare Programs.

11. Maintaining availability of adequate medical liability and health and accident insurance.

Group 2. Business dealing with the official operations of the Society through its proper agents and agencies:

All official concerns of: The House of Delegates and its committees; officers of the Society and the Board of Trustees; the Judicial Council; the official liaison committees; the standing committees; the Welfare Committee and its four subcommittees; and the special committees to the Society, the House of Delegates, the Board of Trustees, and to the Welfare Committee and its subcommittees.

Group 3. Business deriving from the administration of Society concerns with reference to organized medicine:

1. *With county societies*—presenting and cooperating in the carrying out of all recommendations, projects and programs originating with the State Society; and informing and advising county medical societies with reference to their handling of local programs and problems.

2. *With specialty societies*—channeling through "official intermediaries" all matters originating with our Society for their official cooperation;

processing all requests for our Society's official consideration and action emanating from the specialty societies; and cooperating, through conferences and meetings, in the solution of special problems.

3. *With the American Medical Association*—at all levels, taking care of matters of common concern in the fields of legislation, public relations, and all special services; achieving effective representation for The Medical Society of New Jersey in the House of Delegates of the A.M.A., and in approved conferences and meetings of the A.M.A. and of other state medical societies.

4. *With the Woman's Auxiliary to The Medical Society of New Jersey*—rendering and receiving cooperation and assistance at state and at county level.

5. *With representatives of the health insurance industry*—particularly the Medical-Surgical Plan of New Jersey and the Hospital Service Plan of New Jersey.

Group 4. Business arising from the administration of matters with reference to associated and cooperating non-medical groups and associations, including lay health organizations:

1. *State Government*—all branches are involved, especially the executive, the legislative, and the judicial; the Departments of Health, Education, Labor, Institutions and Agencies, Law and Public Safety; the professional boards; and the Divisions of Welfare Services, Motor Vehicles, Temporary Disability Benefits, and Workmen's Compensation.

2. *Allied Professions*—nursing, dentistry, pharmacy, the bar, and the hospital association.

3. *Other Agencies*—all civic, community, and service groups, at state and local levels.

Group 5. Business dealing with the relations of doctors, individually and collectively, with the general public:

1. Responsibility for all official publicity, including the presentation of speakers with official approval; responsibility for the channeling of matters which involve the Society's public relations interests.

2. Responsibility for cooperating with the Judicial Council and the statewide judicial mechanism of The Medical Society of New Jersey in handling all complaints and grievances.

3. Preparation and distribution of fortnightly *Health Hints* to the newspapers of the State, and of monthly *Junior Health Hints* to the schools enrolled for that service.

4. Preparation and distribution of official news releases, and dissemination of authoritative information to news agencies.

5. Preparation and publication of the *Periodic News Letter* to cooperating agencies, as required.

Approved. Recommendation of reference committee that above resume be published in an early issue of the Membership News Letter, and that it be prepared in a compact form for distribution upon request to the membership—Approved (page 395)

STANDING COMMITTEES

Finance and Budget

(Reference Committee "B")

David B. Allman, M.D., Chairman, Atlantic City

A review of the expenses and accounts to date indicates that the individual accounts are sound and that a favorable balance in the total budget can be anticipated.

JOURNAL

The Publication Committee is commended for its continued excellent financial status. No budget appropriation for Journal publication has been requested for the past two years, and the committee makes no request for funds next year. In addition, the committee makes no request for Journal office expenses and travel. It will operate solely on its advertising income.

BUDGET FOR 1958-1959

Below is a copy of the proposed budget for 1958-59 which has the approval of your committee and the Board of Trustees.

AMERICAN MEDICAL EDUCATION FOUNDATION

Up to this year the contribution to A.M.E.F. has caused a deficit in our finances due to the fact that the contribution has been made on a calendar year basis and the appropriation has been on a fiscal year basis. To make up this deficit $25,000 was appropriated in last year's budget, but it was recommended that the contribution for 1957 be $10,000. This contribution was made last December. The Board of Trustees has since recommended to the Finance and Budget Committee that consideration be given to contributing an additional $15,000 to A.M.E.F. for 1957. Your committee, after reviewing the accounts and determining that there would be a balance in the current budget at the end of the year, unanimously voted that the additional $15,000 should be contributed to A.M.E.F. in recognition of the honor bestowed upon this Society by having one of its members, your chairman, serve as President of the American Medical Association this year; and that the contribution be made as a one-time supplemental grant. The Board of Trustees concurred in this recommendation and this supplemental grant has been made.

To inject a personal note at this point, I am honored by this additional contribution and the generosity of my own Medical Society.

Your committee has included in the proposed budget a $25,000 contribution to A.M.E.F. for 1958, which has the approval of the Board of Trustees.

1959 ASSESSMENT

Last year it was necessary to raise the per capita assessment to meet the budget and to bring the surplus account up to the desired figure of $100,000.

As a result of economy on the part of your officers and committees this year, the increased revenue from this year's dues, and larger membership, an assessment of $30 in 1958 will provide the sum required to finance the Society's activities. Your committee is very proud that in this time of rising costs, it can report to the membership a reduction of $10 in the per capita assessment.

Your committee approves, as does the Board of Trustees, that the 1959 assessment be $30 per member.

RECOMMENDATIONS

1. That the 1958 contribution to A.M.E.F. be in the amount of $25,000.
2. That the budget for 1958-59 be adopted in the sum of $193,299.
3. That the 1959 assessment be adopted at $30 per capita.

PROPOSED BUDGET FOR 1958-1959

A-1	Executive Salaries	$ 42,215.00
A-2	Executive Office Salaries	34,120.00
A-3	Executive Office Expenses	2,500.00
A-4	Executive Office Travel	2,825.00
A-5	House Maintenance	13,233.00
A-6	Treasurer	2,930.00
A-7	Finance and Budget	100.00
A-8	Secretary	1,745.00
A-9	Salary Taxes	1,773.00
A-10	Insurance	2,264.00
B-1	Journal Publication	——
B-2	Journal Office Expenses	——
B-3	Journal Office Travel	——
C-1	Welfare	900.00
C-2	Legislation	7,500.00
C-3	Public Health	1,200.00
C-4	Public Relations	8,100.00
C-5	Medical Practice	800.00
D-1	President & Other Officers	5,145.00
D-2	A.M.A. Delegates	7,965.00
D-3	Woman's Auxiliary	9,134.00
D-4	Medical Education Committee	100.00
D-5	Liaison Committees	300.00
D-6	Directory, Membership, Physicians Placement	5,000.00
D-7	Emergency Medical Service, Civil Defense (CD-DC)	100.00
*D-8	American Medical Education Foundation	25,000.00
D-9	Archives and History	100.00
D-10	Blood Bank Commission	250.00
D-11	Medical Defense and Insurance	250.00
E-1	Board of Trustees	3,000.00
E-2	Contingent	5,000.00
E-3	Judicial Council	750.00
E-4	Legal Counsel	4,000.00
E-5	Medical Service Administration	5,000.00
	TOTAL	$193,299.00

*Article X of the Constitution reads: " . . . During the annual meeting, funds may be appropriated by the House of Delegates for the expenses of the annual meeting, for publications for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates then present, and approved by the Board of Trustees."

On the basis of this, the contribution to the A.M.E.F. must be voted as a separate item.

Approved. Reference committee recommendation that the Society's 1958 contribution to AMEF be in the amount of $25,000—Approved **(page 396)**

Publication

(Reference Committee "B")

Fred B. Rogers, M.D., Chairman, Trenton

The Journal of The Medical Society of New Jersey, under the capable editorship of Dr. Henry A. Davidson, continues to educate and inform our membership each month. Our Journal has rated high in comparison with other state medical publications in the past decade. This position of excellence, largely attributable to variety and interest of material published, is mainly due to the work of Dr. Davidson and Mrs. Miriam N. Armstrong, Assistant Editor.

The financial condition of The Journal is sound—due in large part to our loyal ethical advertisers.

During 1957 The Journal published 592 pages of text and 930 pages of advertising for a total of 1522 pages. The 592 pages of text break down as follows:

327	pages of Original Scientific Articles
28	pages of Historical Articles
116	pages of State Activities
35	pages of Editorials
23	pages of Book Reviews
25	pages of County Society Reports
17	pages of Announcements
21	pages of other material
592	

Thanks are in order for Drs. Joseph E. Mott and C. Spencer Davison of the Publication Committee, as well as the editorial staff and contributors, for another successful year of the Society's publication.

One of the gratifying incidents of the past two years has been the increasing frequency with which other publications have asked permission to reprint some of Dr. Davidson's editorials. Such requests have come from other state journals, from house organs of pharmaceutical and other companies, and from medical student publications. The "Authors' Clinic" which appeared periodically in 1956 is still a magnet for reprint requests. This series of columns has been expanded into a book ("Guide to Medical Writing") which has attracted favorable notices and reviews in the world of medical literature.

This is the third year the Publication Committee makes no request for funds for publication of The Journal. In addition, no appropriation is being requested for Journal office expenses and travel. The Journal will operate solely on the income from advertising. For the past few years The Journal has realized a balance from advertising income over publication costs, which has been held in the reserve account. In November 1957, with the approval of the Board of Trustees, the Publication Committee transferred $5,000 from its reserve account to the Medical Student Loan Fund.

Approved (page 396)

Medical Defense and Insurance

(Reference Committee "D")

J. Wallace Hurff, M.D., Chairman, Newark

ACCIDENT AND HEALTH INSURANCE

Ever since the inception of our accident and health insurance program with the National Casualty Company 25 years ago this month, there has been a constant increase in the number of policyholders. We have reached an all time high of 3,622 policyholders.

During the past year, claims were paid to 414 of our members—one out of every 9 of our policyholder members receiving benefits. Again, the company's policy of prompt and liberal claim settlements is reflected in the fact that there have been no requests for arbitration of any claim disagreements.

We are pleased to record that we have had a quarter of a century of satisfactory relationship with the National Casualty Company in the operation of our accident and health insurance plan, which has been administered for us during the entire period by E. and W. Blanksteen of Jersey City.

The National Casualty Company continues to be rated by Alfred M. Best & Company as A-plus (Excellent), which is the top rating granted any insurance company—a rating based on excellent management, financial stability, and just claim settlements.

The committee reviewed a supplemental plan of accident and health insurance issued by the Nationwide Mutual Insurance Company of Columbus, Ohio, an affiliate of the National Casualty Company. This policy will make available an additional $400 monthly accident and health benefit as a supplement to our present coverage, which is written for limits up to $600 monthly benefits.

This new plan—which is based upon the same principles of coverage we made famous under our present basic Physicians Special Policy in effect with our Society for many years—provides for five years of accident coverage from the first day, with six months of partial disability; and for sickness benefits commencing with the eighth day, with a limit of two years for any one sickness.

The Nationwide Mutual Insurance Company's contract differs from the National's basic policy in this respect: it has an age limit of 70 years, whereas the National Casualty Company's policy has no age limit for renewal.

RECOMMENDATION

Since this is additional coverage, we strongly recommend that the House of Delegates approve the accident and health coverage offered by the Nationwide Mutual Insurance Company of Columbus, Ohio, and that we continue to endorse E. and W. Blanksteen as our official broker for accident and health coverage.

PROFESSIONAL LIABILITY INSURANCE

The report of your committee on medical liability insurance for the year 1957 is based on a twelve month experience on a calendar year from January 1, 1957 to December 31, 1957.

STUDY NO. 1

Year	Claims Reported
1948	85
1949	102
1950	93
1951	89
1952	105
1953	103
1954	95
1955	126
1956	126
1957	164

Obviously there has been a sharp increase in the number of claims reported in 1957 as compared with the immediately previous year. For the decade, the claims incidence has gone up from 85 to 165—practically a 100 per cent rise.

A dollarwise graph is available but is not presented in this report. It shows a moderate increase in potential liability on claims.

Study 2 represents a picture on a county basis for your consideration. We call to your attention that for the 12 month period ending December 31, 1957, 18 counties reported claims, 3 counties no claims, totaling 163 claims for the period.

Comparing this period with the 10 month period from March 1, 1956 to December 31, 1956, 16 counties reported an increase in the number of claims, 4 counties reported a decrease in the number of claims, and 1 county reported no change.

During the term of 9 years and 10 months from March 1, 1948 to December 31, 1957, all counties reported one or more claims and a total of 1065 claims was reported.

In considering the number of claims reported on the basis of approximately 4,000 doctors insured, we estimate that present experience would indicate that one out of every 3.7 doctors has reported a claim during the past 9 years and 10 months. For the year 1957, we estimate that one doctor in 25 reported a claim. The increase in the number of claims was fairly consistent throughout the state.

Study No. 3 compares the types of claims reported for the twelve month period from March 1, 1955 to March 1, 1956 and the 10 month period from March 1, 1956 to December 31, 1956 with twelve month period from January 1, 1957 to December 31, 1957.

In reviewing the breakdown of the types of claims affecting the various divisions of the

practice of medicine, it becomes quite apparent that the loss ratio has changed very markedly from year to year, emphasizing the committee's contention that security from a professional liability standpoint lies in the overall protection of our profession where one group protects the other.

Study No. 3 indicates a substantial increase in the number of claims reported in some of our specialty groups. Further, under the heading of antibiotics, with the exception of one previous case in 1955, we do not recall this type of claim's being listed in our previous reports. Your committee desires to make a further statement relative to antibiotic claims, at an early date, after clearing certain legal questions.

We have noticed that younger physicians purchase their liability coverage on a minimum basis because of economic factors. Too often as the volume of their work increases they do not heed our warnings and they expose themselves to judgments greatly in excess of the limits of their coverage. The committee has reviewed specific instances where doctors are definitely underinsured from the liability standpoint, and it wishes to call the attention of the members of the Society to the importance of inspecting the limits of coverage which they are now carrying. In view of

STUDY NO. 2

9 YEARS-10 MONTH PERIOD FROM MARCH 1, 1948 TO DECEMBER 31, 1957

	12 Month Period from March 1, to March 1								10 Mo. 3/1/56 to	1/1/57 to	9 Years	County Society
	1948	1949	1950	1951	1952	1953	1954	1955	12/31/56	12/31/57	10 Months	Membership
Atlantic	—	1	3	—	1	1	3	4	5	8	26	162
Bergen	4	6	4	4	13	10	12	10	10	16	91	596
Burlington	—	—	—	—	—	—	—	2	1	—	3	87
Camden	2	1	1	2	1	—	4	8	1	2	22	317
Cape May	—	—	—	—	—	—	—	1	—	1	2	38
Cumberland	2	—	2	1	2	—	1	—	—	1	9	78
Essex	24	27	28	29	31	28	21	24	31	43	286	1,437
Gloucester	2	—	—	1	2	—	—	—	1	2	8	67
Hudson	7	20	12	15	19	11	13	21	9	13	140	597
Hunterdon	—	—	—	—	2	1	—	—	1	2	6	46
Mercer	3	3	7	6	2	3	7	11	2	6	50	387
Middlesex	7	4	6	4	8	9	2	8	6	14	68	278
Monmouth	6	11	6	3	5	7	5	7	13	12	75	280
Morris	1	2	2	2	1	3	1	4	1	3	20	229
Ocean	2	3	—	1	1	2	4	—	2	3	18	56
Passaic	11	12	16	12	8	12	13	12	10	16	122	554
Salem	—	—	2	3	—	—	—	1	1	—	7	50
Somerset	1	—	—	—	4	5	1	—	1	1	13	92
Sussex	—	1	2	—	—	—	—	—	1	—	4	40
Union	12	10	2	6	5	9	7	11	10	19	91	524
Warren	—	—	—	—	—	1	1	1	—	1	4	37
	84	101	93	89	105	102	95	125	108	163	1065	5,952

STUDY NO. 3

TYPES OF CLAIMS REPORTED	March 1, 1955 to March 1, 1956	Mar. 1, 1956 to Dec. 31, 1956	January 1, 1957 to Dec. 31, 1957
Obstetrics and gynecology	14	8	17
Surgery	21	21	23
X-ray	4	0	3
Orthopedics	7	9	11
Eye, nose & throat	11	7	3
Anesthesia	9	9	18
Physio-therapy	1	4	4
Genito-urinary	3	3	5
Neuro-psychiatry	5	0	2
Dermatology (no x-ray therapy)	0	0	3
General practice			
Patient injured, result of falls	8	4	18
Needles and injections	13	11	12
Antibiotics	1	0	5
Improper or incomplete diagnosis	6	9	7
Miscellaneous	15	15	16
Unclassified	7	8	6

the trend towards larger verdicts we would recommend that our members increase their coverage in order that they will have protection commensurate with present conditions. It is the best judgment of this committee that every member should protect himself to the extent of a basis of $50,000/$150,000 limits.

Your committee is surveying the opinions of those defense attorneys who have been employed by the insurance company with the hope that their frank, constructive criticisms of our profession's weaknesses and strengths will assist us in presenting our membership with some information which may aid in the reduction in the number of claims. Because of past experience there is no question in our minds that some of this information would be of definite value.

During the year there have been several inquiries relative to the advisability of purchasing professional liability coverage through foreign carriers not licensed in New Jersey. We call attention of those interested to the following articles: "Loopholes in Your Malpractice Coverage," *Medical Economics,* March 3, 1958; "Surplus Line Laws Inviting Horde of Nondescript Foreign Companies Under Aegis of Lloyds," *United States Investor,* December 7, 1957; and "Insurance Inquiries," *United States Investor,* March 1, 1958.

RECOMMENDATION

Your committee strongly recommends the continuance of the United States Fidelity and Guaranty Company as our liability carrier. And it is unanimous in its recommendation that we continue the services of Faulhaber & Heard, Inc., as our broker for professional liability coverage. This firm has been for many years of inestimable value to the committee.

Reference committee recommendation that the word "extent" in the sentence "It is the best judgment of this committee that every member should protect himself to the extent of a basis of $50,000/$150,000 limits." be changed to "minimum"—Approved.

Approved as amended (page 399)

Medical Education

(Reference Committee "D")

SHERMAN GARRISON, JR., M.D., Chairman, Bridgeton

In view of the widely differing requirements, in hospitals and county medical societies throughout the state, for programs in medical education, the Medical Education Committee makes the following recommendations to the House of Delegates:

1. That medical educational programs continue to be organized and presented at county medical society or local hospital level.

2. That hospitals and county medical societies feel free to consult with and to avail themselves of the cooperation of the Medical Education Committee.

3. That every responsible group within The Medical Society of New Jersey keep in mind that the Medical Education Committee is prepared to collaborate in arranging any worthy educational program properly presented.

4. That a library of information on medical films, kinescopes, and audio-digest titles be maintained by the committee at the Executive Offices of the Society in Trenton in order to facilitate procurement of audio-visual aids by medical groups within The Medical Society of New Jersey.

Approved (page 399)

Annual Meeting

(Reference Committee on Miscellaneous Business)

JEROME G. KAUFMAN, M.D., Chairman, Newark

The Annual Meeting Committee, perhaps more than any other committee in this Society, has the good fortune to see the actual results of its work. We begin our plans in the early fall by meeting with the section officers. The Scientific Program stems from this one meeting. Shortly thereafter the annual meeting schedule is outlined, the exhibit spaces are assigned, and this is all followed by the innumerable details necessary for the conduct of the convention.

The advance program was mailed to the membership in February, and the committee expresses its appreciation to the Subcommittee on Public Relations for allocating the *Membership News Letter* for this purpose.

With the cooperation of Paul Klemtner & Company, Inc., a medical advertising company in Newark, a motion picture program has been arranged for this year. The company donated its services in organizing the film program. Appreciation is hereby expressed to Paul Klemtner & Company, Inc., for this valuable addition to our annual meeting.

Those in attendance at the annual meeting are urged to visit the scientific, educational, and technical exhibits. They will contain much information of interest and will be presented in a most attractive manner.

The House of Delegates has previously approved the following convention dates which have been confirmed with Haddon Hall.

1959—Saturday, April 25—Wednesday, April 29
1960—Saturday, May 14—Wednesday, May 18
1961—Saturday, May 13—Wednesday, May 17

Because of the heavy convention schedule each spring in Atlantic City, it has been advisable to set meeting dates at least four years in advance in order to insure reservations of the desired dates and hotel. The committee presents the following recommendation concerning the annual meeting for 1962:

RECOMMENDATION

That the 196th Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City, beginning Saturday, May 12, through Wednesday, May 16, 1962.

Approved (page 402)

Scientific Exhibit

(Reference Committee on Miscellaneous Business)

THOMAS K. RATHMELL, M.D., Chairman, Trenton

This committee originally had a very experienced chairman, Dr. William H. Hersohn, of Atlantic City, but by his sudden and untimely death last summer the Society was deprived of a faithful and energetic leader. It has been a privilege for me to succeed Dr. Hersohn as chairman of this committee.

The committee met early last fall and reviewed the list of prospective exhibitors. An invitation list was prepared to which applications for exhibit space were mailed. The committee noted that some scientific exhibits were on the borderline—or possibly over the line—into commercialism. The following policy for scientific exhibits was adopted:

It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey—in instances where a pharmaceutical company has aided in the production of an exhibit either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints of articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

There will be a total of 32 exhibits—25

scientific exhibits, plus 7 educational exhibits.

Two classes of awards will be presented for the most outstanding scientific exhibits—first and second place in all categories, and first and second place for New Jersey exhibitors.

Your committee feels that the scientific and educational exhibits are of exceptional quality and will be of great interest to the membership. We hope and urge that all who attend the annual meeting will take the opportunity of spending some time in visiting the exhibits.

The committee was greatly aided in its activities by Mrs. Edith L. Madden, Administrative Secretary, and her staff.

Approved (page 402)

Scientific Program

(Reference Committee on Miscellaneous Business)

Edward E. Seidmon, M.D., Chairman, Plainfield

Early last fall, the scientific program for the 1958 Annual Meeting was organized at a meeting with the section officers. One new section has been added—Preventive Medicine. The Section on Anesthesiology will not meet this year.

Seventy-eight speakers are listed for the Scientific Program—31 guest speakers, and 47 member speakers. All sections were urged to make their programs attractive to the general membership. The annual meeting is a "medical forum," and sections were urged to use member speakers.

The section officers were most cooperative in submitting their programs in time for the advance announcement of the annual meeting in February, and the speakers also have been cooperative in submitting abstracts of their talks for publication in the final program and by providing necessary information dealing with the presentation of their papers so that all equipment and facilities required could be made available.

We believe the scientific program will be outstanding, and we hope members will attend the sessions.

Approved (page 402)

Advisory to Woman's Auxiliary

(Reference Committee on Miscellaneous Business)

L. Samuel Sica, M.D., Chairman, Trenton

In accordance with the precedent of other years, the Advisory Committee to the Woman's Auxiliary met in June of 1957 to discuss with the President of the Auxiliary the proposals for projects and programs for the ensuing year. All the proposals were weighed in terms of their value both to the public and to The Medical Society of New Jersey. In consequence, it was possible to obtain early approval of the Board of Trustees for programs that have been effectively followed through the year.

In its many activities the Woman's Auxiliary has been in close and commendable cooperation with this committee and with our Society. I should like to mention certain activities and achievements which are especially worthy of note:

Funds were raised in the amount of $5,062 in 1956-57 and in the amount of $2,736 in 1957-58 thus far, for the American Medical Education Foundation. This fund-raising was accomplished by various types of projects in the counties.

Members of the Auxiliary have cooperated in gathering biographic materials of the doctors in their respective counties. Three of the counties have already finished this task.

The Community Home Makers Service is fostered by the members of the Auxiliary in six of the counties. The possibility of establishing Community Home Makers Service in other counties is being given earnest study.

In the counties, with increasing frequency health films are being presented to the public under the auspices of the Auxiliary. This is a program which promises to become progressively popular. All films shown are A.M.A. approved.

The members of the Auxiliary are to be commended for their efforts in raising funds for the Medical Student Loan Fund of The Medical Society of New Jersey. Since 1955 they have raised over $2,000.

During the year 1957-58 they have awarded twenty-six nursing scholarships.

The President of the Auxiliary, Mrs. John C. Voss, was asked to speak at a dinner meeting given by the Morris County Medical Society. The purpose of the meeting was to consider the formation of a woman's auxiliary in that county. Morris is one of the two counties in the state in which there is no auxiliary. We hope that Morris County will decide to establish one.

Ten issues of the Auxiliary *New Jersey Newsletter* have been published. The listing of the Auxiliary officers was published in an early edition, thus eliminating the expense of a separate publication.

When help was called for on legislative matters, members of the Auxiliary have responded promptly and effectively.

The Auxiliary continues to foster public relations meetings at county level, using only programs approved by the county medical society. The Auxiliary is always ready to cooperate in any program the county societies wish to bring before the public. Your committee urges component societies to take advantage of the assistance thus offered.

Your committee wishes to record its appreciation of the generous and understanding cooperation which has been evidenced by representatives of the Auxiliary throughout the year. Close liaison has been constantly maintained, with—we feel—increased advantages to the Woman's Auxiliary and to The Medical Society of New Jersey.

Approved (page 402)

Honorary Membership

(Reference Committee on Resolutions and Memorials)

Aldrich C. Crowe, M.D., Chairman, Ocean City

No names have been submitted for Honorary Membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year.

No action (page 401)

Welfare

(Reference Committee "E")

F. Clyde Bowers, M.D., Chairman, Mendham

The Welfare Committee held three meetings during this administrative year and is unhappy to report that the attendance has been very poor. The Board of Trustees took cognizance of this apparent lack of interest on the part of our membership and has so notified the component societies. If your Welfare Committee is to continue in an effective manner, it will be necessary for representatives from the counties regularly to attend meetings of the Welfare Committee. These meetings constitute the one opportunity, between sessions of the House of Delegates, for representatives from all component societies to be heard on

matters of importance to The Medical Society of New Jersey.

At the first meeting last July, Mr. Anthony P. Alfino, Assistant Manager, Labor Relations and Legal Dept., Chamber of Commerce of the U.S., Washington, D.C., addressed the Welfare Committee on the subject of impact of labor organization on medicine. He emphasized the immense powers exercised by organized labor. He said that unions today are limiting individual freedom, and described attempts to unionize hospital employees. He discussed the "informal" socialization of medicine in the establishment of union health centers. Mr. Alfino expressed the opinion that doctors must help solve these problems by making sure that third parties do not have control of the expenditure of funds for health purposes, and he urged all doctors as a group to make common cause with business to see that control of welfare funds now being spent by unions does not remain in the hands of a special group.

A portion of the last meeting of the Welfare Committee on April 13 was devoted to a discussion of the Forand Bill. The committee was addressed by Olin D. Meeker, M.D., Riverside, Connecticut, a member of the American Medical Association's Committee on Legislation, and by Mr. Ardell T. Everett, Second Vice-President of the Prudential Insurance Company of America, as a representative of the Health Insurance Council. Mr. Robert Boyd, Past-President of the New Jersey Hospital Association, also participated in the discussion.

The Welfare Committee, at each meeting, considered the reports of its two special committees and of its four subcommittees. The activities of these committees are described in their individual reports. Not all recommendations of these committees were endorsed by the Welfare Committee. Several, after review and consideration, were returned for future study and clarification. However, most of the considerations and the recommendations of the special and subcommittees received the approval of the Welfare Committee and, later, approval of the Board of Trustees.

Approved (page 400)

SPECIAL COMMITTEES TO THE WELFARE COMMITTEE

Cancer Control

(Reference Committee "E")

Asher Yaguda, M.D., Chairman, Newark

The Special Committee on Cancer Control met in Trenton at the beginning of the year and laid out an ambitious program, part of which was approved by the Board of Trustees. This has been implemental in the preparation for Journal publication of three articles dealing with recent advances in the diagnosis and treatment of cancer.

Efforts were also made to coordinate the work of this committee with that of the Cancer Control Division of the State Department of Health. As part of that endeavor, your chairman has been invited by the State Department of Health, Division of Chronic Illness Control, to attend the Public Health Service Cancer Control Regional Conference in New York on April 22, 1958, together with Dr. Stella Booth, coordinator of the State Department of Health's Cancer Control Program. The information obtained through this Cancer Control Regional Conference will be studied by our Committee in an effort to improve our concept of the cancer problems in this state and to obtain the best results through cooperation with the State Department of Health's Division on Cancer Control and with the New Jersey Division of the American Cancer Society.

Approved (page 400)

Maternal and Infant Welfare

(Reference Committee "E")

JOHN D. PREECE, M.D., Chairman, Trenton

The activities of the Special Committee on Maternal and Infant Welfare this year can be divided into two parts.

The first has been a continuation of the work of past years in collecting and classifying maternal deaths throughout the state. The value of this part of our program cannot be overemphasized. This year it has indicated a new danger to the lives of pregnant women. Our summary has shown pneumonia to be a major threat for the first time in the history of the committee. In 1957 pneumonia ranked as the second largest cause of maternal deaths in New Jersey. A comparison with similar studies carried on in other states will give a more accurate indication of the gravity of this report.

The second part of the committee's program has been the revision of the old questionnaire for the reporting of maternal deaths. In conjunction with the Bureau of Maternal and Child Welfare of the New Jersey Department of Public Health, a new and more efficient method of reporting is being devised. The committee has marked this project for completion in 1958.

Approved (page 400)

SUBCOMMITTEES

Legislation

(Reference Committee "E")

C. BYRON BLAISDELL, M.D., Chairman, Asbury Park

H. HALE HOLLINGSWORTH, M.D., Co-Chairman, Clifton

This committee has met frequently since last May to consider both state and national legislation. The Legislative Analyst has continued to render invaluable assistance to the subcommittee. He was retained on the same basis of remuneration and services as last year. All bills at state level affecting health and the practice of medicine have been analyzed by him, considered by this subcommittee, and recommendations forwarded to the Welfare Committee and the Board of Trustees. Only infrequently has a recommended position of the subcommittee been modified or resubmitted for further study, and no bill truly inimical to organized medicine has thus far become law.

STATE LEGISLATION

Certain types of bills recur year after year, designed to weaken or evade the provisions of the Medical Practice Act; to extend the scope of practice and enlarge the privileges of practitioners who are not doctors of medicine; to establish as compensable service-acquired disabilities such as heart disease, hypertension, and tuberculosis when incurred by policemen, firemen, and (this year) volunteer firemen; to require tests for drunken driving which could invade persons' constitutional rights; to control the sale and packaging of proprietary and non-poisonous medicines. There are a few more of lesser interest, and some affecting health insurance for state employees—all of which must be watched closely.

Advances are being made by legislative enactments in the field of environmental health, especially to control water and air pollution, radiation hazards, and garbage disposal. Problems of the aging and control of virus diseases are likewise subjects of occasional bills.

On March 24 a very successful reception

and buffet was held by the Society for members of the Legislature, at the Hotel Hildebrecht. Well over one hundred persons attended. We were honored by the presence of Governor Meyner and fifty senators and assemblymen. Twenty-three of our officers and members represented The Medical Society of New Jersey and acted as hosts. The subcommittee is indebted to the Executive Officer and his secretary for taking care of all the details.

Should state legislative activities require it, a supplemental report concerning matters which develop subsequent to the preparation of this report will be submitted to the House.

NATIONAL LEGISLATION

On the national level much is transpiring of which this House of Delegates and the membership at large should be fully aware. Organized labor is making a strong and determined bid to get control of Congress and is advancing Social Security benefits, especially for the aged, by pushing the Forand Bill and others like it in an all-out propaganda campaign. Recently Labor sent 2,200 emissaries to Washington to work on the congressmen with a great show of strength and determination. Mr. Meany and Mr. Reuther also met with the President in a widely publicized conference.

The American Medical Association has come alive as never before, under Dr. Allman's leadership, to join with other strong organizations in combating this 'give-away" program by which the government would cumber the lives of citizens with oppressive and increasing burdens of taxation and control. We are allied with the American Hospital Association, the American Nursing Homes Association, and the American Nurses' Association in a Joint Council to advance our ideas, resist this threat to freedom and quality in the practice of medicine, and to gather facts to present to Congress to show that no such revolutionary program such as AFL and CIO are advancing is justifiable or desirable. The insurance industry is actively engaging in this campaign with us, as are many other strong national business organizations.

Here at home our fourteen congressional district keymen are charged with the responsibility of influencing New Jersey's two senators and fourteen congressional representatives. With the help of local groups, the Woman's Auxiliary, and our twenty-one county societies if we work diligently we can make our representatives aware of our concerns, and appreciative of our determination as citizens to do all in our power to prevent the passage of legislation of this type.

In Washington we were able to secure Representative Kean's promise that he would vote against releasing the Forand Bill from the House Ways and Means Committee. Of twenty-five members of that committee, twelve seem to be against, thirteen for the Forand Bill. If only one more switches to our side, the bill could be bottled up.

More on this will unquestionably be reported before the House of Delegates. The serious and mature consideration of every member of our Medical Society is necessary right now.

Approved (page 400)

Medical Practice

(Reference Committee "E")

IRVING KLOMPUS, M.D., Chairman, Bound Brook

Our work this year has been centered mainly on a study of the "Relative Value" Fee Schedule. This is designed to assign values to various medical and surgical procedures in an orderly manner. It is an attempt to help the doctor set fair values on his services. It is designed to be flexible so as to vary with the general economy. Adoption of a schedule would free the profession of frequent "bargaining" sessions with groups such as Medicare, and state and private insurers. Most important, this is a device or method set up by doctors, rather than something imposed from outside.

The committee has had several other projects during the year such as defining ophthalmologist, optometrist, and optician; and passing upon the propriety of physician's announcements. It has also kept the new disability provision of the social security law under observation.

Approved (page 400)

Public Health

(Reference Committee "E")

Robert S. Garber, M.D., Chairman, Princeton

Significant progress was made by the committee this past year through the aid of its six special committees. One need only refer to the detailed reports of each committee to discern the considerable interest and attention which focused on the activities of each group and its numerous accomplishments. A recommendation—made by last year's subcommittee and approved by the Welfare Committee and the Board of Trustees—relative to the appointment of liaison personnel to lay organizations has proved to be effective in a number of instances. We were gratified to find that responses did aid considerably in bridging a gap between our Medical Society and some other organizations in the state.

Our committee received a request through the Board of Trustees from the President of the Council for Local Public Health Services to aid in the establishment of boards of health in each county, as well as to discuss the Council's statewide program of "analysis of health needs." The Chairman met with Mrs. Paul Rauschenbach, President of the Council, and Dr. Aronson of the New Jersey State Department of Health, and subsequently invited the Chairman of the Committee on Educational and Scientific Trust from the State of Pennsylvania to meet the entire Subcommittee on Public Health to discuss the Pennsylvania program. As a result of this meeting, considerable information was received, and the committee called upon Dr. Aronson to formulate a summary of the Pennsylvania plan compared with the existing situation in New Jersey, and to incorporate recommendations for consideration and action.

The Subcommittee on Public Health also acted upon the request of the President of the Veterinary Medical Association for the opportunity to initiate discussions regarding mutual problems between the two societies. The Board of Trustees has approved our recommendation for the appointment of a consultant from the Veterinary Medical Association to this committee.

Continued work lies ahead relative to a satisfactory program for appropriate recognition of the role of the psychologist as a member of the clinical team in the management of psychiatric disorders. This remains as an unresolved problem, but efforts are being made to facilitate an early resolution of the difficulties through the Mental Health Committee.

The report of the Special Committee on School Health submitted in February 1957 to this committee remains unresolved as of this date.

The Subcommittee on Public Health worked with a special ad hoc Committee on Asiatic Influenza, and with the Special Committee on Traffic Safety in its effort to effect a better working relationship with the Director of the Division of Motor Vehicles, and to acquire prompt resolution of a number of delicate problems referred to the Special Committee on Conservation of Vision.

The Chairman wishes to express to all active members of the various special committees and their chairmen his deep appreciation for their efforts.

Approved (page 400)

Public Relations

(Reference Committee "E")

JOHN F. KUSTRUP, M.D., Chairman, Trenton

The Subcommittee on Public Relations carried out its functions as outlined by the Board of Trustees. Three full committee meetings were held in the course of the year, together with special conferences of individual members entrusted with reponsibility for particular projects.

CONTINUING PROJECTS

The projects approved for continuation throughout the year included:

(1) Publication and distribution of the *Junior Health Hints* series to schools, *Health Hints* to the press, *Membership News Letter*, and *Periodic News Letter* to cooperating agencies.

(2) Preparation and publication of special news releases and publicity materials as required from time to time in furtherance of the Society's business and interests.

(3) Preparation for publication and distribution of a membership guide booklet.

(4) Continuance of a consultative service in support of the public relations activities of component societies.

(5) Completion of the format and achievement of the adoption of a New Jersey Medical-Press Guide to Cooperation.

(6) Encouragement of indoctrination programs under the sponsorship of component societies.

(7) Responsibility for the bestowal of the annual Golden Merit Awards.

(8) Maintenance of a press clipping service for the Society's public relations features, releases, and press notices.

(9) Preparation and presentation of suggestions for more efficient management of meetings of county societies.

(10) Encouragement of the use of family and or individual health records.

THE GOLDEN MERIT AWARD

No public relations activity of recent years has given such universal satisfaction as the bestowal of the Golden Merit Award. This award was established by the Board of Trustees upon the recommendation of your committee last year. The first awards were made in 1957; they will continue through succeeding years. The purpose of the award is to give deserved recognition and honor to members of The Medical Society of New Jersey who have held the degree of Doctor of Medicine for fifty years or more. The Golden Merit Award proved to be a source of heartwarming happiness both to the men and women receiving it and to all of us of the Society presenting it to them. In 1957, one hundred and seventy-seven awards were bestowed. According to our present knowledge, in 1958 twenty-six awards will be given.

HEALTH HINTS, JUNIOR HEALTH HINTS, AND SPECIAL NEWS RELEASES

Your committee is pleased to report that with each passing year our *Health Hints* and *Junior Health Hints* gain in popularity and general favor.

Health Hints are a fortnightly feature supplied, under the aegis of the committee, to 273 daily and weekly newspapers and house organs throughout New Jersey. As a matter of fact, *Health Hints* sometimes leap the boundaries of the State. Twice recently they have been picked up by the wire services and have been published from coast to coast. One *Health Hint* was quoted in *Time* magazine. *Health Hints* are issued over the name of Michael S. Newjohn, M.D.

The *Junior Health Hints* for the past three years have been published in booklet form. At the beginning of the school year they are made available, upon request, to teachers and nurses in the junior high schools and high schools of the state. Each booklet contains thirty-two papers to serve as the basis for thirty-two sessions of classroom instruction in health, one period a week through the school year. In 1957, three thousand copies of this forty page booklet were printed for distribution.

From time to time the committee cooperates with other agencies of the Society in publicizing significant activities. Typical this year was the support of the Eye Health Screening Program which was conducted by the Society through its Special Committee on the Conservation of Vision. During the week of September 15, almost 600 news releases were sent to newspapers, radio stations, and cooperating agencies.

NEW JERSEY MEDICAL-PRESS GUIDE

Work has gone forward this year, between a committee of the New Jersey Press Association and this committee, to evolve an acceptable guide for medical-press cooperation in New Jersey. Agreement has about been reached on the final format, and it is our hope that it will be possible to submit the proposed guide for the consideration of this House during the current annual meeting.

PRESS COVERAGE FOR ANNUAL MEETING

Your committee, for the past several years, has sponsored a Press Room at the annual meeting. It is supervised by the Executive Officer and the members of your committee; the secretary to the Executive Officer is in charge. Through the Press Room, information is given to press representatives, interviews are arranged, and publicity pictures scheduled. Advance and spot news releases are handled through this unit. In 1957 our annual meeting was written up—in coverage embracing all its features—in a grand total of 220 newspaper articles and one editorial. Thirty-six pictures were published, and five special pictorial features were run. The Golden Merit Award won the giant's share of publicity, garnering 80 articles and 16 pictures of 31 recipients.

MEMBERSHIP GUIDE BOOKLET

Final compilation and publication of the Membership Guide Booklet necessarily must wait upon the completion of revision of the constitution and bylaws, which serve as a basic guide for all membership activities. As soon as these materials are available, the project will be carried through to completion.

CONDUCT OF MEETINGS OF COUNTY SOCIETIES

Last year your committee reported that questionnaires had been sent to all component county societies asking for details of the management of county society meetings, with particular emphasis upon technics that have proved successful in improving membership attendance. A copy of the results of the questionnaire was subsequently sent to the chairman of public relations and the secretary of each component society.

From the results of the questionnaire, your committee has made the following observations which may be of interest:

(1) The larger the membership, the lower the percentage of members attending.

(2) The fewer the meetings, the better the attendance.

(3) Speakers on general rather than specific subjects seem to draw larger attendance.

(4) Joint meetings—with the Woman's Auxiliary or other county organizations—result in increased attendance.

(5) Dinner meetings or meetings at which a collation is served—provided that expenses are kept down—result in increased attendance.

(6) The more compact the agenda and the more lively the pace of the meeting, the better the interest and attendance.

On the basis of these observations, your committee suggests that program chairmen or planning groups might weigh the desirability of changes in programs—on an experimental basis—embracing the following:

(1) Reduction of the number of meetings held in the course of the year.

(2) De-emphasis—at least on a limited basis—of scientific presentations.

(3) Speeding up of business meetings—or business portions of meetings—by having the executive committee pre-consider matters to be brought before the general assembly so as to present only important or controversial items.

(4) Utilization of joint meetings, or of sociability features such as dinners or collations.

Probably there is no one best formula for all component societies to follow, but your committee feels that in the interest of unity and organizational solidarity and strength the problem merits painstaking consideration and effort.

The work of this committee has been carried out faithfully in an attempt to further good public relations of The Medical Society of New Jersey between doctor and doctor, doctor and patient, and medicine as an organized unit with the general public.

Approved (page 400)

SUPPLEMENTAL REPORT

The Subcommittee on Public Relations, with the approval of the Board of Trustees, is pleased to submit to the House of Delegates the accompanying "New Jersey Joint Medical-Press Guide For Cooperation." This Guide

was evolved by the Subcommittee on Public Relations and a committee of the New Jersey Press Association. The Guide in its present form has been approved by the Board of Trustees of our Society and by the Executive Committee of the New Jersey Press Association. It will be presented for adoption at the next general meeting of the New Jersey Press Association. Favorable action by the House of Delegates of The Medical Society of New Jersey is respectfully recommended.

NEW JERSEY JOINT MEDICAL-PRESS GUIDE FOR COOPERATION

PURPOSE

The purpose of this guide—evolved and adopted by The Medical Society of New Jersey and the New Jersey Press Association—is to provide a basis for mutual understanding, confidence, and cooperation in New Jersey among members of both organizations.

PREAMBLE

Members of the Medical Profession and members of the Press are both dedicated to the service of the public. Members of the Medical Profession render their services to individuals, whereas the members of the press render their services to the public at large. Occasionally conflicts of interest arise because of misunderstandings. Adherence to this guide will help 1) to eliminate or minimize such conflicts of interest, 2) to insure that the physician will be protected in his aim to serve the welfare of his patient, and 3) to assist the members of the press in their aim accurately and objectively to report news of public concern.

PRESS GUIDE

Members of the press recognize that the primary obligation of the physician is to protect the health and well-being of his patient, and that for him this obligation takes precedence over all others.

Accordingly, the members of the New Jersey Press Association agree to instruct their staff members:

1) To refrain from any demands or actions which might adversely affect the progress or well-being of the patient.

2) Whenever possible, to obtain information concerning a physician or his patients from him or from other authorized and officially approved sources, remembering that, because of the canon of medical ethics against self-advertisement, the physician will be disinclined to permit the use of his name, except in unusual instances.

3) To make certain that information concerning a physician or his patients received from unauthorized sources is carefully checked and confirmed before publication; and where quotations are used, to preserve accuracy in content and context.

4) To respect the individual citizen's right under the law to be secure against invasion of his privacy; and to realize that, because of that right, the physician may disclose only such information as the patient or those acting in the patient's interest specifically authorize.

5) To use good editorial judgment in handling information which, without benefit to the public, might injure the reputation or well-being of the patient or his physician.

6) To make every reasonable effort to contact the designated spokesman of the county medical society for official information or comment concerning medical news of general concern.

MEDICAL GUIDE

Physicians recognize that 1) the press, serving "the people's right to know," is dedicated to discovering and publishing news of interest and concern; and 2) the reporting of news must be done with speed as well as accuracy.

Accordingly, the members of The Medical Society of New Jersey agree:

1) To assist authorized representatives of the press promptly to obtain accurate information of public concern, within the limits of proper regard for the patient's privacy.

2) In such instances, to identify the patient, give the general nature of ascertained injuries or diseases, and the probable outcome.

3) To respect the canon of medical ethics against self-advertisement or self-praise.

4) To designate an official spokesman or spokesmen for state and county medical societies who will be available to authorized representatives of the press promptly to transmit or supply official releases, or information or comment concerning medical news of general public concern.

5) To extend equal courtesy and cooperation to all duly accredited representatives of the press.

Approved (page 400)

Chronically Ill

(Reference Committee "E")

WILLIAM H. HAHN, M.D., Chairman, Newark

The committee held one meeting during the 1957-1958 season. It considered further the material submitted by the Commissioner of State Department of Institutions and Agencies, covering present rules and regulations, and the suggestions for new regulations, governing medical care in nursing homes, together with the request for help in devising a fee schedule for the new Old Age Assistance program.

Publication in THE JOURNAL of The Medical Society of New Jersey, of an excerpt from the manual of the Department of Institutions and Agencies was recommended by the Committee, and approved by the Board of Trustees of The Medical Society of New Jersey.

The committee considered the problem presented by representatives of the State Consultant Committee on Community Home-Maker Service, regarding an area of activity of visiting home-makers. The Committee on Community Home-Maker Service made recommendations permitting the home-makers to engage in specified activities.

These recommendations were approved by the committee, and forwarded to the Subcommittee on Public Health. They were later approved by the Board of Trustees.

The committee's recommendation for the continued and renewed efforts to stimulate the formation and to support the operation of Committees on the Chronically Ill in all component societies, was also approved and implemented by the Board of Trustees.

Approved (page 400)

Conservation of Hearing and Speech

(Reference Committee "E")

S. EUGENE DALTON, M.D., Chairman, Ventnor

The Special Committee on Conservation of Hearing and Speech is happy to report excellent progress for the past year and to present its recommendations for 1958-59:

1. The Board of Trustees approved the Organizational and Procedural Code for Hearing and Speech Centers. Copies will be forwarded to interested individuals and organizations upon request.

2. Report of the activities of the three hearing and speech centers:

A. The Henry A. Barkhorn Memorial Hearing and Speech Center in Newark continues to make splendid progress and is expanding its activities to service a wider area.

B. The Trenton Hearing and Speech Center, at St. Francis Hospital, was equipped by that Hospital and the Department of Health. The Trenton Junior League is paying the salary of the hearing and speech therapist and is assisting in the operation of the center. The center has developed and expanded rapidly. It is expected that in the near future it will be self supporting.

C. The Atlantic City Hearing and Speech Center, located in the Atlantic City Hospital, started its operation in July 1957. The center was made possible by the generous help of the Administrator of the Atlantic City Hospital and of its Board of Governors, who supplied the rooms and furnishings. The State Health Department purchased the technical equipment and will pay the salary of the hearing and speech therapist for two years. Steady progress has been made since the opening of this center.

RECOMMENDATION

That a thorough investigation be made into the possibility and desirability of encouraging the establishment in New Jersey of a center for the training of audiologists and speech pathologists, with programs leading to a doctoral degree.

Approved (page 400)

Conservation of Vision

(Reference Committee "E")

A. M. K. Maldeis, M.D., Chairman, Camden

During the year about to close the Special Committee on the Conservation of Vision has been busy with a number of problems and projects, some of which are necessarily continuing. One of the meetings was held jointly with the Special Committee on School Health further to discuss school eye screenings. The chairmen of county conservation of vision committees were invited and attended in very good numbers. Pre-school examinations were also discussed. The responsibility of parents in the determination of the health of children was stressed. More uniform methods of screenings are necessary and should be under the direction and supervision of doctors of medicine. Study of this problem based upon survey of existing conditions is being continued.

In September of 1957 an Eye Health Screening Program, sponsored by The Medical Society of New Jersey, was conducted throughout the state under the chairmanship of Dr. Arthur E. Sherman. Screening situations were operated at which over 4,000 persons were checked. A similar program is planned for the week beginning September 22, 1958.

The following recommendation was adopted:

"Inasmuch as sunglasses are a dangerous handicap to vision after dusk, it is recommended that—especially as a means of avoiding accidents involving pedestrians and motorists alike—sunglasses be not worn after sundown."

Dissemination of this recommendation was urged, and it was made the subject of a recent *Health Hint*.

To achieve a better understanding of medicine's interest in public projects of lay organizations—such as the care of the blind—a top-level conference of representatives of the Medical Society and the district governors of Lions Clubs of New Jersey has been authorized by the Board of Trustees and is expected to be held shortly.

Methods and eye standards used in the examinations for automobile driving licensure in New Jersey are under consideration. A tour by the committee of one of the Motor Vehicle Department's facilities is arranged for an early date.

Contact lenses are rapidly becoming a matter of public concern. They are the subject of much advertising — sometimes misleading — which often creates confusion in the minds of the public. Consideration of this situation by a group of ophthalmologists will be given.

Co-sponsorship by the Special Committee on the Conservation of Vision and the Special Committee on the Chronically Ill was agreed for an exhibit at the 1958 annual meeting of the Medical Society in Atlantic City. The exhibit is to feature some diseases of the eye.

Routine correspondence and other matters have, we hope, been satisfactorily handled. The committee has endeavored to approach and deal with its problems by positive and constructive action.

Approved (page 400)

Mental Health

(Reference Committee "E")

Frederick A. Erskine, M.D., Chairman, Linwood

The Special Committee on Mental Health considered the following matters in 1957-58.

1. Continued concern with border-line practitioners, especially as they affect psychiatry (with discussion of *modus operandi* for handling such cases) occupied a prominent place in the consideration of this committee. County society committees on Mental Health are advised to remain ever-alert to this problem. Instances of violation should be reported to the State Board of Medical Examiners for proper action.

2. The status of neurologic and psychiatric services in general hospitals was discussed and encouragement derived from the trend to establish such units in general hospitals all over the state. The committee is of the opinion that continued efforts are called for to achieve this goal.

3. The A.M.A. Conference on Mental Health was conducted in Chicago. Your chairman and Dr. Robert S. Garber attended as New Jersey delegates, and discussed, among many other items, psychiatric units in general hospitals.

4. The chairman and members of your committee served, during the course of the year, as liaison representatives with various state organizations and participated in numerous miscellaneous conferences and lectures on problems relating to mental health.

Approved (page 400)

Rehabilitation

(Reference Committee "E")

ELMER J. ELIAS, M.D., Chairman, Trenton

The program of 1957-58 has been a continuation of that established in 1956-57, namely:

1. Education of physicians as to the significance of rehabilitation:

(a) Committees have been established in all counties to date except Cape May.

(b) An increased interest has been manifested by the county chairmen on rehabilitation, and programs on rehabilitation are being promoted for the near future.

(c) The investigation and survey as to source of patients and treatment facilities in all communities are a matter of considerable importance and will require a longer period of time than first anticipated to determine the situation more accurately.
When these studies have been completed the committee proposes that a directory of rehabilitative services can be published by the Medical Society, giving accurate information as to the availability of such services throughout the state.

2. A meeting was held with county chairmen to discuss county problems in the field of rehabilitation, and an initial study has been stimulated that will be carried to each county throughout the state.

The importance of rehabilitation continues to be stressed not only on a state-wide basis but throughout the nation, as was evidenced by the report of the Committee on Rehabilitation of the American Medical Association. The essence of this report is that the rehabilitation of the patient is the responsibility of the physician.

3. Two meetings were held with representatives of the New Jersey Rehabilitation Commission who were given the opportunity to explain the purposes and the functioning of the Commission.

RECOMMENDATION

That the present program be continued for 1958-59.

Approved (page 400)

Medical Student Loan Fund

(Reference Committee "B")

F. Clyde Bowers, M.D., Chairman, Mendham

The Medical Student Loan Fund, established by the House of Delegates, is becoming more widely known. As a result, more New Jersey medical students are contacting our committee and applying for loans.

The Fund started with the sum of $15,065.25 (from the abolished Permanent Capital Fund). To this was added $1,153.81 contributed by the Woman's Auxiliary, $1,000 from the Pfizer Golf Tournament, and $5,000 from The Journal Reserve Account. During the year loans totaling $4,650 were made:

Two students at Howard University—one from Hudson County and one from Mercer County.

One student at Meharry Medical College from Mercer County.

One student at Bern University from Essex County.

One student at Jefferson Medical College from Burlington County.

One student at New York Medical College from Middlesex County.

The committee is limited to granting loans up to 20 per cent of the Fund in any year. The current balance in the account is $17,569. We have a promise of approximately $5,000 from the proceeds of the 1958 Annual Meeting, and approximately $1,500 from the Woman's Auxiliary. On the basis of these figures, the committee will be able to grant loans only to a total of approximately $4,800 next year. However, applications for loans have already been received—all of which are felt to be worthy and should be granted—in furthering the medical careers of future New Jersey physicians.

The committee feels that the existence of the Medical Student Loan Fund should be widely and continually publicized to the members of The Medical Society of New Jersey, and that contributions should be encouraged to be made to the general fund or as specific memorial grants.

Approved (page 396)

SUPPLEMENTAL REPORT

The Board of Trustees of The Medical Society of New Jersey, at its regular meeting on April 20, 1958, authorized the establishment of a memorial to Dr. Albert B. Kump. It was unanimously agreed that this be known as the Albert Barker Kump Memorial Grant, included within the framework of the Medical Student Loan Fund. It is hoped that $5,000 will be realized to this end, and as of this date (May 16, 1958), $780 has been received.

The Medical Student Loan Fund is an excellent means of providing an extraordinary service to deserving New Jersey medical students, and also for establishing favorable publicity for our Society. Under the present proposal this grant would also serve as a permanent living memorial to a man who gave much to our Society. The committee hopes that each member of this Society will avail himself of this opportunity to participate in the establishment of a memorial which will perpetuate the name of one who contributed so unstintingly to our Society.

Approved. Reference committee urged continued contacts with component societies encouraging individual and group contributions on a voluntary basis—Approved (page 396)

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The Physicians Placement Service continues to furnish interested physicians with descriptive lists of New Jersey areas suitable for the establishment of a practice. As an additional service, lists of registrants containing pertinent background information, are also made available to interested parties—including community officials wishing to encourage physicians to locate in their areas; established physicians seeking an assistant or associate; industrial representatives in need of additional medical personnel; and various state departments employing physicians.

This year 204 physicians registered with the Placement Service, 78 of whom had originally communicated with the A.M.A. The remaining 126 directed their original inquiry to The Medical Society of New Jersey, either by mail, telephone calls, or personal visits. Of the total, 73 remain on the active list, 29 have located in this state, and the balance of 92 have either located elsewhere or failed to acknowledge follow-up communications.

As the placement program goes forward, it becomes evident that most of the registrants wish to enter into some type of association, rather than to establish a solo private practice. Most applicants seek an association with an already established physician, or a medical group; and, with few exceptions, they wish to specialize. Applicants also are tending to register far in advance of the date of their availability.

Routine clerical procedures connected with the operation of the Placement Service are carried out by members of the executive office staff. The Placement Service, in effect, maintains a center for exchange of information between community and physician, for their mutual benefit.

Approved (page 399)

Traffic Safety

(Reference Committee "D")

A. M. K. MALDEIS, M.D., Chairman, Camden

The Special Committee on Traffic Safety has met on several occasions for the purpose of organization and discussion toward the development of policy and plans for the future. At one meeting the Honorable Frederick J. Gassert, Jr., Director of the Division of Motor Vehicles of New Jersey, was our guest. He is desirous of the cooperation of physicians in the common problem of traffic safety. An invitation for the committee to visit and inspect the Driver Clinic of the Motor Vehicle Department at Baker's Basin on April 16, 1958, has been accepted. A study of forms used in present examination procedures was suggested.

Among the items discussed to date have been:

1. The importance of emphasizing the moral aspect of reckless driving.
2. The possibility of adopting dependable "constants" for determining physical unfitness to drive.
3. Prohibition of the sale, except on prescription, of medications which diminish physical alertness or efficiency, or alter the mental state of the driver.
4. The desirability of a campaign to induce physicians sternly to warn patients using certain medications not to drive.
5. The importance of encouraging the establishment throughout New Jersey of trauma teams in all hospitals.
6. The preparation and publication in THE JOURNAL of The Medical Society of New Jersey, under the auspices of the special committee, of educational articles directed to member-physicians.

7. The preparation of educational materials to be made available through physicians' offices to patients.

8. The possibility of recommending physical re-examination of all drivers at regular intervals.

9. Possible support of a campaign against improper and unnecessary use of dark glasses.

Traffic safety is everybody's problem, and physicians can help much in dealing with it. The committee expects shortly to present some suggestions by means of which the sad toll of human life as a result of automobile accidents may be reduced. In the meantime, physicians are urged to caution people about the use of drugs which create changes in mental attitudes; to emphasize the fact that alcohol and gasoline cannot mix; to advise the driver, who, in the physician's opinion, is a hazard to himself and others, not to drive; and to practice and encourage courtesy on the road.

Approved (page 399)

Widows and Orphans of Medical Men

(Reference Committee "D")

HARRY H. FARB, M.D., Chairman, Newark

No problems were brought to the attention of the committee. There are no recommendations.

Approved (page 399)

Revision of Constitution and By-Laws

(Reference Committee on Revision of Constitution and By-Laws)

LOUIS F. ALBRIGHT, M.D., Chairman, Asbury Park

There follows a proposed revision of the first alf of the By-Laws. This was the extent to hich your committee could go this year. Five ull-day sessions were held to accomplish this uch, the last one on May 4—a Constitutional onvention—with representatives of the comonent societies. The proposed revision reeived the almost unanimous approval of the onvention, both delegates and committee embers. In a few instances there were a few ssenting votes. However, the majority lopted the following version completely.

In stopping where we did—at the end of hapter VII—we had another objective in ind. Chapter VIII outlines the committees and their functions. There seems to be mixed feeling about the Welfare Committee—should it be continued, or should it be replaced by a more streamlined and workable arrangement? If the House of Delegates has any expression of opinion about the committee structure, the committee would be pleased to know it.

Your committee feels that the revision is a sound and well organized system of procedural codes. We consider it to be free of elements of unclearness or ambiguity, and to be comprehensive and complete as far as it goes. It has the approval of the delegates to the Constitutional Convention, and we urge its adoption.

Current

BY-LAWS

CHAPTER I — MEMBERSHIP

Section 1 — Personnel

The Fellows and Officers of and all the elected delegates to The Medical Society of New Jersey and the members of component societies in good standing are members of this society. Honorary members are entitled to the rights given them by the Constitution.

Section 2 — Official List of Members

(a) Five days before the first of March, the Treasurer of each component society shall forward to the Treasurer of this Society, a complete list, in duplicate, of all paid up members in good standing with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the official list from the lists so received by the Treasurer and such official list as published shall be prima facie evidence of the right of members to register at the annual meeting.

(b) On the first day of March in each year, the secretary of each component society shall send to the Secretary of this society the following information: names of the officers, reporter and censors, member of the nominating committee, delegates and alternates to this society, complete list of associate members, members elected, deceased, and those who have resigned or moved from the county during the preceding year. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(c) Upon request of the Secretary, the secretary of each component society shall furnish complete lists of the names of all affiliated and non-affiliated physicians resident in the county.

(d) Immediately after December 31 of each year the Secretary of the Medical Society shall notify each county society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date.

Proposed

BYLAWS

CHAPTER I — MEMBERSHIP

Section 1 — Composition

The membership of The Medical Society of New Jersey shall be established by Article IV of the Constitution. When not designated by a qualifying word—such as associate, emeritus, etc.—the term member or membership shall refer to active members.

Reference committee amendment: delete the words "active members" in the last line and substitute: "those members having full privileges, including the right to vote and hold office."—Approved (page 402)

Section 2 — List of Members

(a) Five (5) days before the first of March the treasurer of each component society shall forward to the Treasurer of this Society, a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assesssment covering such membership.

(b) Not later than the first day of March in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deceased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(Delete; unnecessary and unavailable)

(c) Immediately after December 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date; at the same time indicating existing vacancies in the delegation, as defined by Article IV of the Constitution. Associate membership shall not be included in such computation.

(d) Not later than the first day of April in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

Section 3 — Ineligibility

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster shall be entitled to any of the rights or privileges of this society, nor shall he be permitted to take any part in any of its proceedings, until relieved of such disability.

CHAPTER XII — RULES OF CONDUCT

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of The Medical Society of New Jersey in their relations to each other and to the public.

Section 4 — Registration at Annual Meeting

All members and delegates in attendance at the annual meeting of this society shall write their names and addresses on an official registration card which shall be duly presented at the registration desk; failing to do so, they shall be considered as absent.

Section 5 — Credentials

(a) All delegates shall present to the Committee on Credentials a certificate, bearing the seal of this society and the signature of its Secretary. No delegate will be permitted to register or sit as a member of the House of Delegates without such certificate, nor if the component society of which he is a delegate has not paid its annual assessment.

(b) The annual assessment of a component society shall be the dues of at least the smallest number to whom a charter may be granted to form a component society, in accordance with Chapter X, Section 2, of these By-Laws.

CHAPTER II — MEETINGS

Section 1 — Annual Meeting

This society shall hold an annual meeting at such time and place as may be fixed by the House of Delegates or by the Board of Trustees.

Section 2 — Special Meetings

Special meetings of this society or of the House of Delegates shall be called by the President upon the petition of twenty or more members representing four or more component societies, or upon request of the Board of Trustees.

CHAPTER XIII — RULES OF ORDER

The deliberations of the society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order," when not in conflict with this Constitution and By-Laws, unless otherwise determined by a two-thirds vote of its respective bodies.

Section 3 — Ineligibility

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster, shall be entitled to any of the rights or privileges of this Society until relieved of such disability. Nothing in the foregoing shall affect the right of appeal as set forth in Chapter VII of these Bylaws.

Section 4 — Rules of Conduct

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of The Medical Society of New Jersey in their relations to each other and to the public.

Reference committee amendment: change the fourth line to read: "the conduct of members in all categories of The"—Approved (page 403)

(Delete; covered in Chapter II)

(Delete; covered in Chapter IV)

(Delete; to be covered in Chapter X — Finance)

Chapter I approved as amended (page 402)

CHAPTER II — MEETINGS

Section 1 — Annual Meeting

An annual meeting shall be held as provided in Article VIII of the Constitution at a time and place fixed by the House of Delegates or the Board of Trustees.

Section 2 — Special Meetings

Special meetings of this Society or of the House of Delegates shall be called by the President upon the request of the Board of Trustees, or upon the petition of at least five percent (5%) of the membership of this Society representing at least ten percent (10%) of the membership of each of four (4) or more component societies.

Section 3 — Rules of Order

The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order, Revised", when not in conflict with the Constitution and Bylaws.

(From Chapter I—Membership—Section 4)

Section 4
Registration and Identification

Each delegate and member in any category in attendance at an annual or special meeting of this Society shall print his name and address on an official registration card which he shall present at the registration desk. Failing to do so, he shall be considered absent. Upon verification by the Reference Committee on Credentials of his right to register, he shall receive a certificate or badge designating his status.

Reference committee amendment: delete the words in the fourth line: "print his name and address on" and substitute the words: "properly complete"—Approved (page 403)

Chapter II approved as amended (page 403)

CHAPTER III — CONDUCTING THE SESSIONS

Section 1

All registered members may attend and participate in the proceedings and discussions of the general and section meetings. The general meetings shall be for the presentation of the addresses of the President and President-Elect, orations by invited guests, and scientific papers and discussions as provided for in the official program; these meetings shall be presided over by the President, President-Elect or one of the Vice-Presidents. Special section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided for in the program; these section meetings shall be under the guidance of a presiding officer chosen by each section at its last session of the preceding annual meeting.

Section 2 — Committees

The general and section meetings may create committees for scientific investigations of special interest or importance to the profession or public, and may receive and dispose of such committee reports; but no expense shall be incurred in connection therewith until authorized by the House of Delegates and approved by the Board of Trustees

Section 3 — Programs

The order of exercises, papers and discussions, as set forth in the official program, shall be followed from day to day until completed; unless otherwise ordered by the society.

CHAPTER III — GENERAL SESSIONS AND SECTION MEETINGS

Section 1 — General Sessions

All registered members may attend and participate in the proceedings and discussions of the general sessions and section meetings. Upon invitation other registrants may attend. The general sessions shall be for the presentation of the addresses of the President, President-Elect, invited guests, and scientific papers and timely discussions, as provided in the official program. These sessions shall be presided over by the President, President-Elect, or one of the Vice-Presidents.

Section 2 — Section Meetings

(a) Section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided in the program. These section meetings shall be under the guidance of a presiding officer chosen by each section at its last session.

Reference committee amendment: delete the last two words "last session" and substitute the words "preceding meeting"—Approved (page 403)

(b) At a regularly scheduled section meeting committees may be established for scientific investigations of special interest or of importance to the profession or public. No expense to the Society shall be incurred in connection therewith unless authorized by the House of Delegates and approved by the Board of Trustees.

(Delete; covered in Section 1)

Section 4 — Length of Addresses

No address or paper, with the exception of those delivered by the President, President-Elect, and invited orators, shall occupy more than twenty minutes in its delivery or reading; and no member shall speak longer than five minutes, nor more than once, on any subject, unless by permission of the society.

Section 5 — Ownership of Papers

All papers and reports presented to the society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in the JOURNAL of the society or in other medical journals may be granted by the Committee on Publication.

(From Constitution, Article IV, Section 6)

CHAPTER IV — HOUSE OF DELEGATES

Section 1 — Meetings

The House of Delegates shall meet on the first day of the annual meeting of the society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general meetings of the society.

(From Section 6)

Section 3 — Length of Addresses

No address or paper, with the exception of those delivered by the President, President-Elect, and invited guest speakers, shall take more than twenty (20) minutes for presentation; and no discussor shall speak longer than five (5) minutes, nor more than once, on any subject, unless by permission of the presiding officer.

Section 4 — Ownership of Papers

All papers and reports presented to this Society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in THE JOURNAL of this Society or in other medical journals may be granted by the Committee on Publication.

Section 5 — Guests

Upon invitation extended by this Society or any of its members, any person may become a guest during the annual meeting. Physician guests are entitled to attend the general session and section meetings. Non-physician guests may attend the general session, but may attend a section meeting only with the permission of the presiding officer of that section.

Chapter III approved as amended (page 403)

CHAPTER IV — HOUSE OF DELEGATES

Section 1 — Meetings

(a) The House of Delegates shall meet on the first day of the annual meeting of this Society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general sessions and section meetings. Unless otherwise ordered by the House of Delegates, all its sessions shall be in Executive Session.

Reference committee amendment: delete the last two words "Executive Session" and substitute and add the following: "closed session. Closed session shall include officers, delegates, registered members, and guests invited by the Chair."—Approved (page 404)

(b) The annual meeting of the House of Delegates shall consist ordinarily of three (3) sessions. Except as otherwise provided, the principal business of these sessions shall be: First Session: presentation of annual reports, introduction of resolutions, introduction of new business, and assignment of same to reference committees; Second Session: report of Nominating Committee and election; Third Session: presentation of and action upon reports of reference committees, unfinished business, and inauguration of newly elected officers.

(c) Consent of two-thirds (⅔) of the delegates present and voting shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or

(From Chapter I — Membership — Section 5)

Section 2 — Quorum

Twenty members, representing at least four component societies in good standing, shall constitute a quorum. Sessions of the House of Delegates shall be open to all members of the society, but only members of the House of Delegates shall have the right of voice or vote.

Section 3 — Charters

It may issue charters to county societies applying for affiliation with this society.

Section 4 — Authority Over Component Societies

It shall consider the reports of component societies, and have authority to make such recommendations and adopt such measures as may be deemed effective for building up and increasing the interest of these societies.

Section 5 — Final Authority

The House of Delegates or Board of Trustees must approve all memorials and resolutions issued in the name of the society before they can become effective.

(From the Charter)

the Finance and Budget Committee. All new business so presented shall require a three-fourths (¾) affirmative vote of the delegates present and voting for adoption of new business so presented.

Section 2 — Credentials

Each delegate shall present to the Reference Committee on Credentials a certificate bearing the Seal of this Society and the signature of its Secretary. A delegate will not be permitted to register or sit as a member of the House of Delegates: (1) without such certificate, (2) if his assessment has not been paid, or (3) if his component society has not paid its annual per capita assessment.

Section 3 — Quorum

A quorum shall consist of at least ten percent (10%) of the membership of the House of Delegates representing at least ten percent (10%) of the delegation of each of seven (7) component societies.

Section 4 — Voice, Vote, and Discussion

(a) Only members of the House of Delegates shall have the right of vote. The privilege of voice may be extended by the House, at its discretion, to invited members and guests.

Reference committee amendment: change the word "invited" in the last line to the word "other"—Approved (page 404)

(b) The presiding officer, with the consent of the House of Delegates, shall be empowered to limit discussion.

(Delete; covered in Section 5)

(Delete; covered in Section 5)

(Delete; covered in Section 5)

Section 5 — Authority

The House of Delegates shall have the power to:
Prescribe the duties of its officers and its members, fix their compensation, if any;
Assess from time to time an annuity upon the component societies in the ratio of their membership respectively;
Adopt such rules and regulations for the due management of this Society and the several component societies as may be deemed necessary;
Issue charters to county societies applying for affiliation with this Society;

Revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws, upon the recommendation of the Board of Trustees.

Reference committee amendment: at the end delete the words "Board of Trustees" and substitute the words "Judicial Council"—Approved (page 404)

Section 6 — Business During the Last Session

Unanimous consent shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance. All new business so presented shall require a three-fourths affirmative vote for adoption.

(Delete; covered in Section 1 (c))

Chapter IV approved as amended (page 404)

CHAPTER V — SELECTION OF OFFICERS

Section 1 — Nominating Committee

Each component society shall elect at its annual meeting one of its elected delegates to serve as a member of the Nominating Committee of this society, and one of its elected delegates alternate thereto; this elected member, or his alternate, shall present his credentials to the Secretary at the close of the first session of the annual meeting. The Immediate Past-President of this society shall be the member of the Nominating Committee representing the Fellows; if he shall not be able to serve; then at the close of the first session of the annual meeting the Fellows shall elect one of their number to be a member of the Nominating Committee, who shall forthwith present his credentials to the Secretary. The delegates, or their alternates so elected from their respective component societies, and the representative of the Fellows, shall compose the Nominating Committee. This committee shall meet at 8:30 p.m. on the first day of the annual meeting and report the result of its deliberations to the House of Delegates in the form of a ticket containing nominations for each of the offices to be filled, including Trustees, Standing Committees, Councilors, Delegates to the American Medical Association and to other medical organizations.

CHAPTER V — PROCEDURE OF ELECTION

Section 1 — Nominating Committee

(a) Each component society shall elect, at any meeting, prior to March 31st of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary at the close of the first session of the House of Delegates at the annual meeting.

(c) The Immediate Past-President of this Society shall be the member of the Nominating Committee representing the Fellows. If he shall not be able to serve, then at the close of the first session of the House of Delegates, the Fellows shall elect one of their number to be a member of the Nominating Committee. He shall forthwith present his credentials to the Secretary.

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations containing nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

Reference committee amendment: delete the words "containing nominations" in the 10th and 11th lines—Approved (page 405)

Section 2 — Procedure

(a) The Chairman of the Nominating Committee shall be the Immediate Past-President of the society or the member elected by the Fellows. The committee shall elect one of its own members to serve as secretary and to call the roll of accredited members of the Committee as certified by the Secretary of the society. Nominations for all offices, standing committees, delegates to the American Medical Association and other medical organizations, shall be made by individual alphabetic roll call of the counties, the representative of the Fellows being called last. The representative of each county, when its name is called, may place in nomination a candidate, second a nomination, or waive its privilege to another county. The representative of the county so favored may then nominate a candidate or second a nomination, after which the roll call will be continued from the point where it was interrupted. The representative of the Fellows may nominate a candidate or second a nomination, and shall have a vote equal to the vote of a representative of a component society. The secretary shall announce the result of the completion of each call; and if the tabulation of any roll call be challenged, the roll will again be called. A majority vote of the members present shall nominate; and in the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped and the call of the roll shall be repeated until a nomination is made.

(b) The Secretary of the society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all officers, committees and delegates to be nominated.

(c) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.

(d) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

Section 2 — Procedure of Nomination

(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.

The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.

(Delete; covered in (c))

(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.

(c) All nominations should be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.

The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.

The chairman shall have only the right to vote in case of a tie.

The secretary shall announce the result upon completion of each roll call. If the tabulation of any roll call be challenged by any member of the committee, the roll shall be called again. A majority vote of the members present shall nominate. In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. The call of the roll shall be repeated until a nomination is made.

(d) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.

(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

(e) The chairman shall read to the committee this section of the By-Laws (Section 2, Chapter V) before proceeding to any other business.

Section 3 — Time of Report

The report of the Nominating Committee, and the election of officers, standing committees, delegates to the American Medical Association and other medical organizations, shall be the first order of business of the society in the afternoon of the second day of the annual meeting.

Section 4 — Nominations from the Floor

Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the society; except that the President-Elect shall succeed to the office of President without process of nomination and election.

Section 5 — Manner of Voting

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

Section 6 — Beginning of Term of Office

(a) Officers and members of elected standing committees shall assume office immediately after adjournment of the annual meeting at which they were elected.

(b) The term of office of Delegates and Alternate Delegates to the American Medical Association shall begin on January 1 of the year following their election. The terms of office shall be for two years, ending on the second December 31, thereafter.

(c) In the absence of a delegate, any Alternate Delegate who is available shall be eligible to serve.

(Delete; covered in (a))

Section 3 — Report and Election

(a) The report of the Nominating Committee, the submission of nominations from the floor by members of the House of Delegates—if any—and the election shall constitute the principal business of the second session of the House of Delegates.

(b) All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

(c) In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. Balloting shall be repeated until an election is made.

(d) The President-Elect shall advance to the office of President without process of nomination and election.

(Delete; covered in Section 3)

(Delete; covered in Section 3)

(Delete; covered in Chapter VI)

(Delete; to be covered in Chapter VIII)

(Delete; to be covered in Chapter VIII)

Chapter V approved as amended (page 404)

CHAPTER VI — DUTIES OF OFFICERS

Section 1 — President

The President shall preside at all meetings of this society and of the House of Delegates. He shall appoint all committees not otherwise provided for, and shall be ex-officio member of all standing committees except the Nominating Committee. He shall deliver an address at the annual meeting of this society, and shall perform such other duties as custom and parliamentary usage may require.

CHAPTER VI — RIGHTS AND DUTIES OF OFFICERS

Section 1 — The President

The President shall preside at all meetings of this Society and at all sessions of the House of Delegates, unless he shall have appointed a Speaker as provided in Article V of the Constitution.

He shall appoint committee members as provided in these Bylaws and he shall be an ex-officio member of all committees except the Nominating Committee.

He shall be the official spokesman of this Society, and shall perform such other duties and functions as custom and parliamentary usage may require.

Section 2—President-Elect and Vice-Presidents

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties, and in his absence or disability the President-Elect, or the ranking Vice-President shall preside at all meetings of the society and of the House of Delegates, and perform all the duties pertaining to the office. In case of vacancy in the office of President by death, resignation, or removal, the President-Elect, and in his absence, the ranking Vice-President shall perform all duties pertaining to that office until the vacancy is filled by appointment of the Board of Trustees.

Section 3 — Secretary

The Secretary of the society shall have the custody of the Constitution and By-Laws of the society and of the records of the Society and the House of Delegates under the direction of the Board of Trustees. He shall attend all meetings of the society and of the House of Delegates, and shall keep a record of their proceedings. He shall give notice of all general and special meetings of the House of Delegates or of the society, to the members of the said House or society. He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the county societies a list of their representatives in the House of Delegates and the Nominating Committee, and shall publish such lists at such times and in such manner as the House of Delegates may direct.

He shall have the sole custody of the Official Seal of the society and shall affix the same to such correspondence or instruments as the By-Laws may require or the Trustees or the President may direct.

He shall conduct such formal official correspondence in the corporate name of the society as the Trustees or the President may direct. The Board of Trustees shall make suitable provision for the detail and clerical work of the Secretary.

He shall submit annually to the House of Delegates a report of the work of his office, and shall furnish to the Board of Trustees or to the President, upon request, such information as may be necessary for the society's business, and shall perform such other functions as are specified in these By-Laws.

Section 2 — The President-Elect and the Vice-Presidents

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties and functions.

In the absence or disability of the President, his duties and functions shall devolve upon the other presidential officers in the order of their seniority.

In case of vacancy in the office of President, by death, resignation, or removal, the President's functions and duties shall devolve upon the other presidential officers in the order of their seniority. Such service on the part of a presidential officer as Acting President shall not affect or diminish the regular presidential tenure.

Reference committee amendment: delete the words "as Acting President" in the 8th line of the 3rd paragraph, and substitute the words "for a partial term as President"—Approved

(page 405)

Section 3 — The Secretary

The Secretary shall be the official custodian of the Constitution and Bylaws and of the records of this Society and its House of Delegates.

He shall attend all annual or special meetings of this Society and all sessions of its House of Delegates; and he shall keep proper records thereof.

He shall issue official notice of all meetings, annual or special, of this Society or of its House of Delegates.

He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the component societies, a list of their representatives in the House of Delegates and on the Nominating Committee as provided in Chapter I of these Bylaws, and shall publish such lists as the House of Delegates or Board of Trustees may direct.

He shall require and receive from the secretaries of the component societies, a list of their officers immediately following election, and a list of their committee chairmen.

He shall be the sole custodian of the Official Seal of this Society and shall affix it to such documents as the Bylaws may require, or the House of Delegates, the Board of Trustees, or the President may direct.

He shall conduct such formal official correspondence in the corporate name of this Society as the House of Delegates, the Board of Trustees, or the President may direct.

He shall submit to the House of Delegates an annual report of the work of his office.

He shall furnish to the Board of Trustees or the President such information as may be necessary for this Society's business.

He shall perform such other functions as are specified in the Constitution and Bylaws.

He shall be entitled to necessary expenses in attending meetings or otherwise incurred in the transaction of the society's business, as authorized by the Trustees.

Section 4 — Treasurer

The Treasurer shall give bond, at the expense of the society, in such amount as may be required by the Board of Trustees. He shall demand, receive and preserve all funds due the society, together with bequests and donations; and keep a correct list of the same, with the name of each donor. He shall not pay any money out of the treasury except on resolution of the Board of Trustees, or upon voucher of the officer or committee responsible for the expenditure, countersigned by the Chairman of the Finance Committee, and as provided in the annual budget. His accounts shall be audited by the Trustees at such times as the Board or the House of Delegates may order, and he shall render at each annual meeting of the society a full statement of all transactions of his office. Whenever 90 per cent of the annual budget appropriated for any office or committee has been expended, he shall so notify the proper officer or committee chairman. He shall charge upon his books the assessment against each component society at the end of the fiscal year, collect and make proper credits for the same; and perform such other duties as may be assigned to him.

Section 5 — Board of Trustees

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board shall organize by electing a chairman and a secretary; and the chairman shall appoint such committees as may seem necessary or desirable. Meetings shall be called by the chairman, but any four members may require the chairman to call a meeting for such time and place as shall be designated by them in writing. Members shall have at least five days advance notice of all meetings. Nine members shall constitute a quorum.

The Board of Trustees at the organization meeting may appoint an Executive Committee to consist of the chairman of the Board of Trustees, the immediate Past-President, the President, the President-Elect and one elected Trustee to be selected by the chairman of the Board. The Executive Committee shall meet at the call of the chairman of the Board at the time and place designated by him. Its function shall be thoroughly to consider all matters to come before the Board of Trustees for its consideration and action. It shall have authority to take final action on all matters referred to it by the Board of Trustees, with power. In un-

He shall be entitled to reimbursement for expenses incurred in fulfillment of duties imposed by the Bylaws, or authorized by the House of Delegates or the Board of Trustees.

Section 4 — The Treasurer

The Treasurer shall be under bond, at the expense of this Society, in such amount as may be required by the Board of Trustees.

He shall demand and receive all funds due this Society, and shall preserve all funds of this Society.

He shall receive bequests and donations, and maintain a complete record thereof.

He shall not pay money out of the treasury except (1) in amounts as provided in the annual budget, upon voucher of the officer or committee responsible for the expenditure, or (2) in amounts as provided by resolution of the Board of Trustees and for which a voucher has been prepared. All such vouchers shall be approved and signed by the chairman of the Finance and Budget Committee.

He shall render at each annual meeting of this Society a full statement of all transactions of the Treasurer's office.

He shall notify the proper officer or committee chairman whenever ninety percent (90%) of the annual appropriation for any office or committee has been expended.

He shall collect and enter proper credits for per capita assessments received from component societies.

He shall perform such other duties as may be assigned by the House of Delegates or Board of Trustees.

He shall submit his accounts for audit at such times as the House of Delegates or the Board of Trustees may order.

Section 5 — Board of Trustees

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board of Trustees shall organize by electing a chairman and a secretary. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum.

(b) Executive Committee. The President, President-Elect, First and Second Vice-Presidents, and chairman of the Board of Trustees shall compose the Executive Committee. It shall act on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken shall be subject to formal action of the Board of Trustees at its next meeting.

usual circumstances requiring emergency action, when time does not permit the five day advance notice required, for meetings of the Board of Trustees, the Executive Commiittee may act for the Board of Trustees securing concurrence in the proposed action from a majority of the Board of Trustees by telephone (the whole Board to be canvassed) confirmed by telegram or letter, any action thus taken to be ratified by formal action of the Board of Trustees at its next subsequent regular or special meeting. Four members of the Executive Committee shall constitute a quorum.

(b) Powers. The Board shall exercise general supervision over the affairs of the society, with authority to act for the society between annual meetings, and to perform the following functions:

To make recommendations to the House of Delegates;

To advise in the deliberations of the several standing committees;

To supervise the work of the Publication Committee and, when necessary, to appoint an editor and such other assistants as the needs of the society may require;

To determine all salaries;

To pass upon all recommendations for incurring expense, over and above that provided in the budget;

To order all necessary expenditures;

To refer and otherwise dispose of all business, properly arranged for its disposition;

To require and hold the official bond of the Treasurer and to annually audit his accounts;

To fill vacancies in all offices and elected standing committees until the next annual meeting.

In the event of a vacancy in the office of Treasurer, by death or otherwise, the Board of Trustees shall select one of its members to fill the vacancy.

(c) Property. It shall have authority to lease, sell, or otherwise convey or dispose of any or all property of the society, both personal and real, and to execute therefor, good and sufficient lease, deed, or other conveyance.

(d) Finance Committee. Three of its members shall serve on the Committee on Finance in accordance with Chapter VIII, Section 5, of these By-Laws.

(e) Nominees to State Board of Medical Examiners. Acting for the society, and in accordance with the statutes of this state, as vacancies occur in the State Board of Medical Examiners by reason of the expiration of term, or otherwise, of members of said Board representing this society, the Trustees shall nominate for each appointment three members of this society, and the names of such nominees shall then be transmitted by the President of this society to the Governor of the state.

(f) Annual Report. It shall publish annually in the JOURNAL of this society a report of its proceedings and recommendations, and shall render to the House of Delegates a summary of its activities.

(c) Powers. The Board of Trustees shall exercise general supervision over the affairs of this Society, shall have authority to act between annual meetings, and shall perform the following functions:

Make recommendations to the House of Delegates;

Assign business to and advise in the deliberations of committees;

Supervise the work of the Publication Committee, and appoint an editor and such other assistants as the publication of THE JOURNAL may require;

Make suitable provision for the efficient conduct of the business of this Society;

Engage counsel as necessary and negotiate fees for services to be rendered;

Determine all salaries;

Pass upon all recommendations for expenditures in excess of budgetary appropriations;

Bond the Treasurer, the chairman of the Finance and Budget Committee, and other necessary personnel;

Fill vacancies in all offices and elected committees until the next annual meeting, unless otherwise provided in the Constitution and Bylaws.

(d) Property. The Board of Trustees shall have sole authority to lease, sell, or otherwise convey or dispose of any or all property of this Society, both personal and real.

(e) Finance and Budget Committee. Three (3) Trustees shall serve on the Finance and Budget Committee, in accordance with the provisions of Chapter IX of these Bylaws.

(f) State Board of Medical Examiners. Acting for this Society, and in accordance with the statutes of the State of New Jersey, as vacancies occur in the State Board of Medical Examiners, by reason of the expiration of term or otherwise, the Board of Trustees shall nominate for each appointment three (3) members of this Society. The names of such nominees shall then be transmitted to the Governor of the State of New Jersey.

Reference committee amendment: delete the words "by reason of the expiration of term or otherwise," in the 7th and 8th lines—Approved (page 406)

(g) Annual Report. The Board of Trustees shall render annually to the House of Delegates a summary of its activities.

Section 6 — Judicial Councilors

The Judicial Councilors shall be governed by the provisions set forth in Chapter VII of these By-laws.

Section 7 — Term of Office

All officers shall assume office at the close of the last session of the House of Delegates of the annual meeting at which they are elected.

CHAPTER XI — RESIGNATION OR REMOVAL OF OFFICERS

Any officer of this society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws.

Section 8 — Resignation or Removal

Any officer of this Society may resign. He may be removed from office by action of the House of Delegates, if found guilty by that body of neglect of duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (⅔) vote of the delegates present and voting shall be required to effect such removal.

Chapter VI approved as amended (page 405)

CHAPTER VII — JUDICIAL COUNCIL

CHAPTER VII — JUDICIAL COUNCIL

NOTE: No amendments proposed for Chapter VII except in Section 2, as follows:

Section 2 — Councilors

The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of the Society.

Section 2 — Councilors

The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of this Society. The Councilors shall elect their own chairman.

Chapter VII approved (page 407)

(From Chapter V)

CHAPTER VIII — OTHER DELEGATES AND REPRESENTATIVES

Delegates and Alternate Delegates to other medical organizations shall be elected in accordance with the provisions of Chapter V of these Bylaws.

(a) American Medical Association. The terms of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December thirty-first thereafter.

In the absence of any Delegates, any Alternate Delegate shall be eligible to serve.

(b) Other Medical Organizations. When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such Delegates and Alternate Delegates shall be elected for terms of one (1) year.

(c) Representatives. Official representatives from this Society to other organizations shall be appointed by the Board of Trustees or by the President with the approval of the Board of Trustees. Their functions and terms shall not exceed those set forth in their official notice of appointment.

Chapter VIII approved (page 407)

CHAPTER VIII — COMMITTEES	CHAPTER IX — COMMITTEES
(to be revised and considered in 1959)	
CHAPTER IX — FINANCE	CHAPTER X — FINANCES
(to be revised and considered in 1959)	
CHAPTER X — COMPONENT SOCIETIES	CHAPTER XI — COMPONENT SOCIETIES
(to be revised and considered in 1959)	
CHAPTER XI — RESIGNATION OR REMOVAL OF OFFICERS	Included as Section 8 of Chapter VI — Rights and Duties of Officers
CHAPTER XII — RULES OF CONDUCT	Included as Section 4 of Chapter I — Membership
CHAPTER XIII — RULES OF ORDER	Included as Section 3 of Chapter II — Meetings
CHAPTER XIV — CONFERRING THE DEGREE OF DOCTOR OF MEDICINE	Delete as a Chapter of the Bylaws, but retain as an addendum for historical record.
CHAPTER XV — AMENDMENTS	CHAPTER XII — AMENDMENTS TO THE BYLAWS
(to be revised and considered in 1959)	

Approved as a whole as amended (page 407)

REVISION OF CONSTITUTION

(Reference Committee on Constitution and By-Laws)

The following proposed revision of the Constitution was approved by the House of Delegates at the 1957 Annual Meeting, recognizing that such revision must be considered by the House of Delegates for final vote in 1958. In compliance with the Constitutional provision regarding amendments, the proposal was sent to each component society and published in THE JOURNAL in February, 1958.

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey."

ARTICLE II — PURPOSES

The purposes of this Society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance the art and science of medicine, elevate professional standards, safe-guard the interests of, and promote friendly relations among, members of the medical profession;

To promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey; and, in general,

To render the members of this Society most capable of serving mankind.

ARTICLE III — COMPONENT SOCIETIES

County medical societies that hold charters from this Society shall be known, and referred to in the Constitution and Bylaws, as component societies. There shall be no more than one (1) component society in any county.

ARTICLE IV — ORGANIZATION OF THE SOCIETY

Section 1 — Composition

This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing, and Emeritus Members. Honorary Members may be elected, but they shall not be members of the corporate body.

Section 2 — Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society.

Section 3 — Officers

The Officers shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, a Secretary, a Treasurer, the elected members of the Board of Trustees, and the Judicial Councilors.

Section 4 — Delegates

Delegates shall be chosen by and from the component societies, and shall be members of this Society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society's continuing in good standing in this Society.

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March thirty-first of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

(b) Reapportionment. In the event of geographic subdivision of any of the existing counties of New Jersey, and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided.

(c) Delinquency. In the event that a component society becomes delinquent to this Society, its entire delegation shall lose its status for the period of such delinquency.

(d) Vacancy. A vacancy shall exist in the delegation of any component society whenever one (1) of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two (2) consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

(e) Alternates. Each component society shall elect, at any meeting prior to March thirty-first of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate.

A regular delegate, if unable to attend a session

of any meeting of the House of Delegates, may inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when registered and seated in the House of Delegates shall retain his seat during the remainder of the meeting.

Section 5 — Members of Component Societies

All members of component societies in good standing are hereby constituted members of this Society and are entitled to full privileges.

Associate members of component societies in good standing are hereby constituted associate members of this Society, but they may not vote or hold office.

Section 6 — Emeritus Members

Emeritus members shall be physicians who have been members in good standing of a component society for at least twenty (20) years, and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service. Nominations shall be submitted by the component societies, and emeritus membership shall be conferred by a majority vote of the House of Delegates. Emeritus members shall have all the privileges of membership except the right to vote and hold office, and their respective component societies shall not be assessed for such members provided they are carried as emeritus members in said component societies. Emeritus members shall not be included in the membership of a component society when computing the number of delegates to which such society is entitled.

Section 7 — Honorary Members

Honorary members shall be physicians who have attained distinction within the medical profession; or persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trustees shall be officially transmitted to the component societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component societies shall be required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds (2/3) vote of the House of Delegates at the first session. Presentation of the honorary membership shall be made at the closing session of the House of Delegates. Honorary members shall not be members of the corporate body. At no time may the number of living honorary members exceed twenty-five (25).

ARTICLE V — HOUSE OF DELEGATES

Section 1 — Composition

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates.

Section 2 — Speaker

The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.

ARTICLE VI — BOARD OF TRUSTEES

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.

From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between expiration of the second and commencement of the third term. The term of any Trustee commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.

At the first election of officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

ARTICLE VII — JUDICIAL COUNCILORS

The Judicial Councilors collectively shall comprise the Judicial Council which shall be the judicial body of this Society. The House of Delegates shall organize five (5) councilor districts within the State. It shall elect one (1) Judicial Councilor from among the membership of each of the five (5) districts.

ARTICLE VIII — MEETINGS

Section 1—Annual Meeting

This Society shall hold at least one (1) meeting annually. The time and place for such meetings shall be fixed by the House of Delegates. The Board of Trustees may change the time and place when necessary.

Section 2 — General Session

During the annual meeting there shall be at least one (1) general session that shall be open to all registered members and invited guests.

Section 3 — Sections

The House of Delegates or the Board of Trustees may provide for division of the scientific work of this Society into appropriate sections whenever necessity therefor arises.

ARTICLE IX — OFFICERS

Section 1 — Term of Office

The Officers, except the Judicial Councilors and the elected members of the Board of Trustees, shall hold office for one (1) year, or until their successors are elected and installed.

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE X — FUNDS AND EXPENSES

Section 1 — Finances

Current expenses of this Society shall be met by an annual assessment upon each component society in the ratio of its membership, by donation, by sale of this Society's publications, and from miscellaneous revenues.

During the annual meeting, funds shall be appropriated by the House of Delegates for the budgeted items, but for no other purpose, unless authorized by a two-thirds (2/3) vote of the members of the House of Delegates then present.

Section 2 — Incurring Expense

The Board of Trustees may incur any necessary expenses between successive annual meetings.

ARTICLE XI — SEAL

The Seal heretofore adopted and now in use shall continue, unless otherwise ordered by the House of Delegates, to be the Seal of The Medical Society of New Jersey.



Seal of The Medical Society of New Jersey

ARTICLE XII — AMENDMENTS TO THE CONSTITUTION

This Constitution may be amended in the following manner:

A. Procedure for First Year

1. Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

2. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

3. Submission of the proposed amendment in writing at the first session of the House of Delegates.

4. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

5. Referral of the proposed amendment and report thereon to the appropriate reference committee.

6. Hearings on the proposed amendment and report thereon by the reference committee.

7. Report of the reference committee to the final session of the House of Delegates for appropriate action.

8. Acceptance by a majority vote of the members of the House of Delegates present and voting at the final session.

B. Procedure for Second Year

9. Transmittal of the accepted amendment to each component society and publication in The Journal, at least three (3) months prior to the next annual meeting.

10. Adoption by a two-thirds (2/3) vote of the members of the House of Delegates present and voting at the final session.

Approved (page 402)

Medicare Program

(Reference Committee "C")

From the Bergen County Medical Society

Whereas, the Medicare Program administered by The Medical Service Administration of New Jersey (Box 262, Newark 1, New Jersey) has adopted the use of excessively lengthy forms in processing physician's claims for services rendered, and

Whereas, delays of many months in making payments to physicians for services rendered have been experienced, therefore be it

Resolved, that an effort be made to simplify paper work and to expedite payment of physician's claims for services rendered, and be it further

Resolved, that a copy of this resolution be forwarded to The Medical Society of New Jersey for presentation to the House of Delegates at its Annual Meeting in May, 1958.

Approved. Reference committee called attention to the annual report of Medical Service Administration (page 398)

Medical Fees — Medical-Surgical Plan

(Reference Committee "C")

From the Bergen County Medical Society

Whereas, the Medical-Surgical Plan of New Jersey gives recognition to the surgeon in providing a fee schedule for operations, and

Whereas, provision is made for only 21 days of medical treatment in hospital for medical illness, and

Whereas, many serious medical diseases require a longer in-patient stay *i.e.* myocardial infarction, minimum of 28 hospital days, and

Whereas, this and other serious medical illnesses require expert care and more visits and time than allowed for by present $5.00 per day fee, and

Whereas, it is obvious that the internist and general practitioner treating serious illness are unfairly treated by the present Medical-Surgical Plan of New Jersey, therefore be it

Resolved, that steps should be taken to erase this injustice and bring medical fees to a par with surgical fees as soon as reasonable in the present contract of the Medical-Surgical Plan of New Jersey known as "The Doctors' Plan" and that the contract be rewritten or amended.

Reference committee recommendation for amendment in the fifth paragraph: Delete the wording: "it is obvious that the internist and general practitioner treating serious illness are unfairly treated" and substitute the wording: "the internist and general practitioner treating serious illness have frequently noted insufficient recompense"—Approved

Reference committee recommendation for amendment in the sixth paragraph to change the word "injustice" to "inequity"—Approved

Approved as amended. Reference committee directs attention to recent increased benefits enacted by Medical-Surgical Plan (page 398)

Medical-Surgical Plan — Income Limit Regulations

(Reference Committee "C")

From the Hudson County Medical Society

Whereas, the Medical-Surgical Plan has certain financial restrictions in the insurance plans it offers, and

Whereas, it is believed these restrictions are frequently not adhered to, to the detriment of patients and physicians, therefore be it

Resolved, that the Medical-Surgical Plan of New Jersey be urgently requested to review this situation and institute strong measures to remedy it; to consider, among other measures deemed feasible, the use of a rigid financial statement form as a part of the application procedure.

Approved (page 398)

Medical-Surgical Plan and Additional Coverage

(Reference Committee "C")

From the Hudson County Medical Society

Whereas, the individual members of the Hudson County Medical Society have a vital interest in the Blue Shield Plan of New Jersey, and

Whereas, the provision of the contract of the Blue Shield Plan of New Jersey exhibits an inequity working to the detriment of the participating physician and the patient; and which in effect nullifies the Physician Lien Law, therefore be it

Resolved, that the Hudson County Medical Society demand the following policy change be effected by the Medical-Surgical Plan of New Jersey: In third party actions, the participating physician shall not have his fee restricted by the Blue Shield Plan of New Jersey, but shall be entitled to his usual fee.

Recommendation of the House of Delegates that the resolution be not adopted because favorable action had been taken on the subject by previous action of the House—Approved (page 398)

Medical-Surgical Plan and Additional Coverage

(Reference Committee "C")

From the Passaic County Medical Society

Whereas, a preponderant number of the members of the Passaic County Medical Society participate, and have a fundamental interest, in the Blue Shield Plan of New Jersey, and

Whereas, certain conditions embraced in the contract of the Blue Shield Plan of New Jersey are inequitable and unfair and work to the detriment of the participating physicians, therefore be it

Resolved, that the Passaic County Medical Society present for immediate consideration the following proposed revisions to the subscription contract of the Medical-Surgical Plan of New Jersey: That the participating physicians shall be entitled to receive from the subscriber, or covered dependent, the difference between the fee payable by the Blue Shield Plan and the physicians' usual fee in the following cases:

1. Where there is a Third-Party action.
2. Where benefits for physicians' fees are

afforded by any policy or plan in addition to Blue Shield coverage, provided that the fee charged shall not be beyond the total coverage thereof, and be it further

Resolved, that the delegates of the Passaic County Medical Society be instructed to introduce and urge the passage of this Resolution before the Annual Meeting of The Medical Society of New Jersey in May, 1958.

Recommendation of the House that no action be taken on this resolution because the reference committee's previous recommendations for advice of counsel on items 1 and 2 were approved—Approved (page 398)

Medical-Surgical Contract Inequities

(Reference Committee "C")

From the Middlesex County Medical Society
(Re-presentation and Discussion of Issue)

In the January 1958 issue of the Middlesex County Medical Society Bulletin, the proceedings of a conference of the Permanent Committee of Blue Shield and The Medical Society of New Jersey—held July 30, 1957—were published.

The resolution was approved in principle by the House of Delegates at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, N. J., in 1957.

It has been felt by the Medical Insurance Committee of this Society, and by the body at large, that the report of the proceedings requires clear scrutiny and for this reason the original resolution, as adopted, is again presented this year.

The resolution as submitted is as follows:

Whereas, the individual members of The Medical Society of New Jersey have a vital interest in the actual contracts of the Medical-Surgical Plan of New Jersey, and

Whereas, the provisions of the Contracts of the Medical-Surgical Plan of New Jersey exhibit several inequities working to the detriment of both participating physician and the patient, therefore be it

Resolved, that the Middlesex County Component Medical Society demands that the following policy changes be effected by the Medical-Surgical Plan of New Jersey:

1. When the patient has multiple medical-surgical type coverage, either through non-profit or indemnity plans or both, the participating physician shall be entitled to his usual fee or to the value of the total medical-surgical type coverage, whichever is less;
2. Multiple non-profit medical-surgical type coverage, other than duplicate contracts within the same state, shall be allowed;
3. In third party actions the participating physician shall not have his fee restricted by the Medical-Surgical Plan of New Jersey, but shall be entitled to his usual fee or to the combined value of the fee paid by the Medical-Surgical Plan of New Jersey plus any judgment for medical services awarded the patient, whichever is less;
4. When necessary operative and non-operative care is rendered by one or more participating physicians, said operation either incidental to or secondary to the total non-operative care of the patient; the physician or physicians rendering the care shall be entitled to receive both the medical and the surgical fees authorized under the schedule of payments of the Medical-Surgical Plan of New Jersey, and be it further

Resolved, that the Middlesex County Component Medical Society requests that consideration be given by the Medical-Surgical Plan of New Jersey to an increase in its schedule of fees and particularly to an increase in its variety of coverage, similar to that presently in force in neighboring states, where patients in much lower income groups are entitled to a greater variety and degree of coverage.

DISCUSSION

The Middlesex County Medical Society does not wish to present its views in an arbitrary manner, but it cannot help but question the answers and conclusions arrived at by the representative of the Medical-Surgical Plan. The inequities that exist

are the concern of all the members of the component society and it believes that the rank and file membership to the State Society is likewise interested in improving the provisions of the contract.

The membership of this component society is well aware of the provisions of the present contract. Not to attempt to alleviate some of the inadequacies, would be an admission by these members that the present plan is solving all the existing problems for the subscribers and the participating physician. We acknowledge that there is no perfect plan, but every effort must be put forth by all concerned to achieve this goal (of a perfect plan).

The function of the Medical-Surgical Plan is to make available a contract that operates within the present framework of medical practice.

The report of the conference held on July 30, 1957 by the Permanent Blue Shield committee as presented in THE JOURNAL of The Medical Society of New Jersey in the January 1958 issue requires close scrutiny. The component members of the Middlesex County Society are aware that the proceeds of an insurance benefit do not affect the income status of a subscriber, but when these benefits include fees for the professional services rendered by the treating physician who is a participating member of the Medical-Surgical Plan, then the Middlesex County Component Medical Society believes that provisions should be made to change this as requested by the resolution.

It is not reasonable to expect a participating physician to donate a portion of his rightful fee to the subscriber in third party liability cases. It is unreasonable to conclude that payment by a liability insurance company for services of a physician rendered to a subscriber is not necessarily in consideration of same services or obligation as the payment made by the Plan to the physician It is unreasonable to state that such payment generally refers to other matters than the services of a physician. As a matter of fact the liability insurance company and the attorney for the injured person are deeply interested in the amount of the services of the treating physician. Many a verdict by a jury include a specified amount for medical and surgical services.

We do not request that the liability of the Plan be excluded in 3rd party liability cases, but we request a change in the present contract to provide for the payment of the usual fee to the participating treating physician in these cases. The last paragraph of section 526 under (h) on page B-10 of the manual supplied "Participating Physicians" provides for such changes and is as follows:

"Any medical service corporation may classify subscribers whereby under specified circumstances a subscriber or covered dependents may pay a participating physician for medical services an amount in addition to that payable by the corporation for medical services and the subscription certificate issued to any subscriber affected thereby shall contain the provisions thereof and shall specify such circumstances."

In the matter of multiple insurance coverage the following should be considered: The prorating of charges to a sum equal to the doctor's usual fee wherever the patient has multiple coverage; also an escalator clause with a cost-of-living index is a worthwhile consideration.

Under number 4 and the matter of an increase in the schedule of fees we believe that the participation of the rank and file membership of the State Society of New Jersey in exploring changes, taking into consideration the experiences of the Medical-Surgical Plan, is essential.

Another outstanding inequity is present. As the present plan contract exists, a subscriber with an income of $4,000.00 or less is charged the same cost as the one with the $7,500.00 income. This inequity to the subscriber creates a hardship that must not be overlooked.

It is no longer a question of approaching the Department of Banking and Insurance to explore the use of multiple contracts, but to actually formulate and present these multiple contracts and if the need exists to offer "tailor made" contracts. We are living in a free economy and must compete in a healthy and constructive manner with other plans to the benefit of no one individual or group, but to the benefit and well being of the subscriber and the participating treating physician.

Not withstanding all our presentations we cannot help but express our gratitude to the members of the Blue Shield Committee. Recognition must be given to the doctors who had the foresight and courage to initiate the Plan which was originally prepared and approved by physicians for physicians and free from outside pressure.

Recommendation of the House for approval of items 1, 2, and 3, which are being referred to legal counsel by previous action of the House—Approved (page 398)

Surgical Care of Patients with Facial and Jaw Injuries — Medical-Surgical Plan

(Reference Committee "C")

From the Warren County Medical Society

Whereas, trauma to the face and jaws often requires the services of dental surgeons, and

Whereas, dental surgeons are active members of the hospital staff in many hospitals

and are essential members of the medical team necessary to take care of patients with injuries to the face and jaws, and

Whereas, dental surgeons are not now included as participating members by the Medical-Surgical Plan of New Jersey, therefore be it

Resolved, that dental surgeons be authorized to furnish surgical care to patients with facial and/or jaw injuries, and be it further

Resolved, that dental surgeons shall be paid by the Medical-Surgical Plan of New Jersey for such surgical care rendered to subscribers to the Medical-Surgical Plan of New Jersey.

Disapproved. It is the position of this Society that the appropriate method for the provision of insurance plans covering services of those other than Doctors of Medicine is the enactment of enabling legislation for the establishment of plans independent of medical care specifically covering the services of the professional or occupational groups concerned. (page 398)

Blue Cross Inter-Plan Service Bank

(Reference Committee "C")

From the Union County Medical Society

Whereas, it has been brought to the attention of the Union County Medical Society by one of its constituent members that there are certain aspects of our Blue Cross Plan which are not generally appreciated by the membership at large; and

Whereas, these matters concern accidents or illness requiring hospitalization occurring to eligible members and/or their dependents outside of our State; and

Whereas, our present Blue Cross Contract provides in case of out of state hospitalization that indemnities will be limited to the "Blue Cross Inter-Plan Service Bank and the Plan shall not be liable for the balance" (Section VIII, Subscription Contract Hospital Service Plan of New Jersey); and

Whereas, very few members are aware of the meaning of this; therefore be it

Resolved, that this matter be referred to the proper committee of The Medical Society of New Jersey which committee shall investigate this matter, and if it cannot be corrected, it shall at least be brought to the attention of each member of The Medical Society of New Jersey.

Approved. Reference committee recommendation that the Blue Cross be invited to submit for publication in THE JOURNAL of The Medical Society of New Jersey the clarifying details of this Inter-Plan Service Bank—Approved (page 398)

Atomic Warfare

(Reference Committee "D")

From the Cumberland County Medical Society

The Cumberland County Medical Society believes that the atomic arms race can lead to only two possible ends. If present atomic devices are used on an international scale, the involved belligerents will be so devastated as to lose their stature as world powers, and the destruction of our civilization is a not remote possibility. The alternative is to withdraw atomic devices from the field of military weapons.

It is time some responsible group of citizens faced this dilemma realistically. Since we in the medical profession, in envisioning the problems of atomic assault on our cities, have reason to appreciate the magnitude of this problem, and are basically devoted to the protection of the health of our citizens, we feel justified in offering the following resolution for consideration by the House of Delegates.

Whereas, the arsenal of modern atomic

weapons now in existence is capable of the virtual annihilation of the major world powers, whether they be the aggressors or the attacked, should international atomic warfare develop, and

Whereas, intercontinental ballistic missiles soon, if not already, available to the major powers, are impervious to any means of defense known at present, and

Whereas, the evacuation of major centers of population cannot be considered a practical possibility, and

Whereas, poison gas, outlawed by the Geneva Conference of 1925 was not used by the major powers in World War II, though materials for chemical warfare and its defense were constantly available to both sides, and

Whereas, the failure of diplomatic solutions to international problems today leads to no alternative but international atomic warfare, and the destruction of civilization as we know it, therefore be it

Resolved, that The Medical Society of New Jersey as a responsible scientific and humanitarian body, condemn the use of atomic devices against civilian populations and urge its representatives in the Congress and Senate of the United States to take immediate steps towards the organization of a world agreement, under the United Nations, specifically outlawing the use of atomic devices against civilian populations.

Disapproved for the following reasons: (1) The suggestions are already part of the United Nations' deliberations, and are also the national policy of our administration; (2) Responsible persons are already handling the problem. (page 399)

Retirement Plan for Physicians

(Reference Committee "D")

From the Mercer County Medical Society

Whereas, many physicians and/or their families, upon retirement or death, are left destitute or with negligible means of support;

Whereas, the participating physicians of the Medical-Surgical Plan of New Jersey give of their time, knowledge, and skill for payment by fees below the average; and

Whereas, the assets and unassigned reserves of the Medical-Surgical Plan of New Jersey are constantly increasing; and

Whereas, the participating physicians of the Medical-Surgical Plan of New Jersey may appropriately be considered employees or workers of the Blue Shield Plan of New Jersey; therefore be it

Resolved, that The Medical Society of New Jersey organize a retirement plan for the physicians of New Jersey; and be it further

Resolved, that this contribution plan consist of a fund to which contributions will be made by the physicians of New Jersey; and be it further

Resolved, that contributions of participating Blue Shield physicians be made from Blue Shield fees to the fund, and be complemented by contributions from the Medical-Surgical Plan of New Jersey; and be it further

Resolved, that the President of The Medical Society of New Jersey appoint a committee consisting of a representative proposed by each county society; two (2) members of the Board of Trustees of the Medical Society; two (2) members of the Board of Trustees of the Medical-Surgical Plan; a representative of an investment trust company; and an attorney-at-law; and be it further

Resolved, that this committee actively and favorably investigate and devise a method for the accomplishment of these resolutions; and be it further

Resolved, that the report of this committee with its findings be made at a special meeting of the House of Delegates to be held the third week of November, 1958, at Trenton, New Jersey, for deliberation on these proposals.

Disapproved. Reference committee recommendation that such a committee as advocated in the resolution be appointed to thoroughly investigate the problem; and further, that the report of said committee be published in THE JOURNAL of the Medical Society of New Jersey at least one month prior to the 1959 annual meeting—Approved (page 399)

Physical Examination of School Children

(Reference Committee "E")

From the Bergen County Medical Society

Whereas, the present statute of the State of New Jersey concerning the examination of school children makes it mandatory that each child be examined by the school physician or a nurse under his direction, and

Wheras, our County Medical Society, the New Jersey Branch of the Academy of Pediatrics and the School Health Committee of our State Society have recommended that whenever feasible the children be examined by the family physician, therefore be it

Resolved, that our State Society request our State Legislature to amend the present Law, Section 18:14-57 of the Revised Statutes—Chapter 25 of the Laws of New Jersey of 1955, to enable these examinations to be acceptable if performed by the family physician subject to the review of the responsible school physician or inspector, and be it further

Resolved, that a copy of this resolution be forwarded to The Medical Society of New Jersey for presentation to the House of Delegates at its Annual Meeting in May, 1958.

Approved in principle. Reference committee recommendation that resolution be forwarded to Subcommittee on Legislation—Approved (page 400)

Physical Examination of School Children

(Reference Committee "E")

From the Essex County Medical Society

Whereas, the present statute of the State of New Jersey concerning the examination of school children makes it mandatory that each child be examined by the school physician or by a nurse under his direction, and

Whereas, Bergen County Medical Society, the New Jersey Chapter American Academy of Pediatrics, and the School Health Committee of our State Society, have recommended, that wherever feasible, the children be examined by the family physicians, therefore be it

Resolved, that our State Medical Society request our State Legislature to amend the present Law, Section 18:14-57 of the Revised Statutes—Chapter 25 of the Laws of New Jersey of 1955, to enable these examinations to be acceptable, if performed by the family physician, subject to the review of the responsible school physician or inspector, and be it further

Resolved, that a copy of this resolution be forwarded to The Medical Society of New Jersey for presentation to the House of Delegates at its Annual Meeting and Convention to be held in May 1958.

Approved on the same basis as the Bergen resolution (approved in principle and referred to Subcommittee on Legislation) (page 400)

Operating Room Training of Student Nurses

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, there is a developing tendency in this country to reduce the operating room experience required in the curriculum for student nurses, and

Whereas, this movement, if unchecked, may finally result in the complete elimination of all such experience for student nurses, and

Whereas, as members of the medical profession, we recognize the great value of such experience for a student nurse, imparting as it does basic competence in aseptic technic and the ability to perform dependably as a member of the operating team, with consequent enlargement and increase in the value of the services which the student nurse can contribute to patient care, and

Whereas, in times of war or public disaster, the services of as many nurses as possible thus qualified will be critically and immediately necessary, and will constitute a factor determinative of our national survival, therefore be it

Resolved, that The Medical Society of New Jersey express its disapproval and stern opposition to curtailment or withdrawal of operating room experience for student nurses, as incompatible with the rounded development of those professional capabilities desirable and indispensable for the public welfare: and be it further

Resolved, that a copy of this resolution be introduced in the House of Delegates of the American Medical Association at its meeting in San Francisco in June, 1958.

Approved (page 400)

Examination of Hospital Records

(Reference Committee "E")

From the Middlesex County Medical Society

Whereas, Chapter 286 of the Laws of 1945, R. S. 2A:82-41 et seq., allows for the examination of hospital records of patients against whom or by or for whom a claim is asserted for personal injuries or death resulting either under the Workmen's Compensation Act of the State of New Jersey, Chapter 15 of Title 34 of the Revised Statutes, or at law, and

Whereas, the Supreme Court of the State of New Jersey in a recent decision, State vs. Hunt, has stated the doctrine of privileged communication, and

Whereas, certain agencies have sent representatives of minor age to copy hospital charts verbatim without regard to the patient's welfare, and

Whereas, experience under this statute has proved that hospital records have been indiscriminately examined by unauthorized persons, and

Whereas, it is imperative for the protection of the patients that this abuse be stopped, now therefore be it

Resolved, that Chapter 286 of the Laws of 1945, R. S. 2A:82-41 et seq. be amended to allow for examination of hospital records only upon the consent, in writing, of either the patient against whom or by or for whom a claim is asserted for personal injuries or death resulting either under the Workmen's Compensation Act of the State of New Jersey, Chapter 15 of Title 34 of the Revised Statutes, or at law, or by his treating physician or in the event of the death of the said patient, then by his legal representative, or in lieu thereof by an appropriate order of a Court of proper jurisdiction, and be it further

Resolved, that a copy of this Resolution be presented to The Medical Society of New Jersey for action.

Reference committee recommendation that the wording in the sixth paragraph, 10th line, "or by his treating physician" be deleted; and that the words "or incompetence" be added in the 11th line; the 10th and 11th lines then to read: "or at law, or in the event of the death or incompetence of the said patient, then"—Approved.

Intent of resolution approved as amended. (page 400)

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee on Resolutions and Memorials)

The following nominations for election to emeritus membership at the 1958 Annual Meeting have been received from the component societies. Conforming to the provisions of Article VI, Section 7, of the Constitution, all nominees are now and have been members in good standing for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine.

BERGEN COUNTY

Samuel T. Hubbard, M.D., New York City (formerly Hackensack); age 76
Walter W. Mockett, M.D., Maywood; age 60
William L. Vroom, M.D., Ridgewood; age 92

BURLINGTON COUNTY

Elizabeth F. Love, M.D., Moorestown; age 64

CAMDEN COUNTY

Martin H. Collier, M.D., Haddonfield; age 72
Thomas M. Kain, M.D., Camden; age 70

ESSEX COUNTY

George A. McLellan, M.D., Sparta; age 72

Approved (page 401)

William R. Tilton, M.D., Orlando, Fla. (formerly Millburn); age 67

MERCER COUNTY

David B. Ackley, M.D., Trenton; age 82

MORRIS COUNTY

Frank H. Pinckney, M.D., Morristown; age 70

PASSAIC COUNTY

William M. Fielding, M.D., Waldwick; age 70
David R. Crounse, M.D., Passaic; age 91
Lester F. Meloney, M.D., Clifton; age 77
Charles R. Mitchell, M.D., Oakland; age 80
Harry A. Moscoe, M.D., Miami Beach, Fla. (formerly Paterson); age 55
Jacob Roemer, M.D., West Orange; age 76
Nathan Salzman, M.D., Paterson; age 65
William P. Thorne, M.D., Saratoga Springs, N. Y. (formerly Paterson); age 83
Hyman J. Udinsky, M.D., Passaic; age 70
Andrew B. Vanderbeek, M.D., Paterson; age 87
Gerard J. Van Schott, M.D., Manasquan; age 74
Ralph J. Vreeland, M.D., Ridgewood; age 68
Walter M. Winters, M.D., Paterson; age 70

Medical Service Administration of New Jersey

(Reference Committee "C")

The Board of Governors

During 1957, Medical Service Administration of New Jersey has been active in the operation of the City of Newark Medical Plan and the Medicare Program of the United States Government.

NEWARK MEDICAL PLAN

The Newark Medical Plan is designed to meet the needs of the indigent and the medically indigent of the City of Newark on a "cost plus," rather than on an insurance basis; it provides for medical services rendered in the homes of eligible persons by physicians of the patient's choice on a fee-for-service basis.

The Plan is a successful demonstration of the cooperation of an official health agency with a voluntary non-profit agency established by the medical profession in helping to solve the problem of public medical care of the indigent and medically indigent.

Following are the statistics on number of cases and cost of services rendered during 1957 as compared to 1956 and 1955.

The classification of *indigent* is applied to those persons whose names appear on the welfare rolls of the city of Newark; the *medically indigent* are those who are considered by the Social Service Bureau of the City Division of Health as having sufficient income to meet the routine of an adequate standard of living, but lack sufficient income to pay for needed medical care.

INDIGENT (RELIEF) PERSONS

	Year 1955	Year 1956	Year 1957
Mean number of persons on Welfare Rolls during year	5281	3883	4262
Number of cases served	1964	1277	1556
Value of approved services	$6,565.50	$4,605.00	$7,000.50
Cost per capita of relief load	1.24	1.19	1.57
Cost per case per year	3.34	3.60	4.54

MEDICALLY INDIGENT CASES*

Number of cases* served during year	3335	2993	4291
Value of approved services	$11,151.00	$9,969.00	$17,662.50
Cost per case* per year	3.34	3.33	4.11

The increase in the number of cases on relief rolls and those receiving medical care is due to the decrease in employment in this area; the greater cost of the physicians' services is attributable to the combination of unemployment and the rise in the rate of fees paid to physicians, which became effective April 15, 1957. Fees for day calls were increased from $3 to $4 with a $2 fee for each additional patient seen on the same visit, limited to $10 for each call; fees for night calls were increased from $5 to $6, with $3 for each additional patient seen on the same visit, limited to $15 for each call. Night hours have been designated as between 8:00 p.m. and 8:00 a.m. The adjustments in fees and hours were arranged by The Essex County Medical Society by negotiation with Newark City officials.

The Essex County Medical Society has also been most cooperative in supplying many new physicians to the panel available to service the needy of Newark. Sixty-four physicians participated in the program during 1957.

MEDICARE PROGRAM

Having been designated Fiscal Agent by The Medical Society of New Jersey, Medical Service Administration of New Jersey is administering the physicians' portion of the Medical Care Program for dependents of members of the armed services which was implemented by the Department of the Army on December 7, 1956. Under this program, wives (or dependent husbands) and children of persons in military service are entitled to a wide range of services from civilian physicians and hospitals at Government expense.

Considering its novelty and complexity and the fact that the Department of the Army had but a short time to plan for its establishment, Medicare is working remarkably well. Some complaints stem from the detailed and complicated report form and from the fact that in a small proportion of cases, payment to a physician may be delayed for several months.

*The word "case" here means "family" as distinguished from "person" referred to under the report on number of "Persons on Welfare Rolls" above.

The reason for the latter situation is explained below.

With the completion of a full year of operation of the Medicare program on December 31, 1957, a brief review of its accomplishments is submitted herewith:

Of the paid claims, about 63 per cent were for maternity care, 22 per cent were for pediatric care and 9 per cent were for surgical care. At the end of 1957, approximately 80 claims per day were being received and processed.

1,675 New Jersey physicians received fees for services performed for beneficiaries of the Medicare Program during its first fiscal year.

The processing cost per claim for the first half year (December 7, 1956 to June 30, 1957) was $11.44. This cost is not truly representative of the unit cost since the volume at that period was necessarily low and the initial cost of the program (contract negotiations, printing, distribution of manuals, and training programs) was included in the figure. In the fourth quarter of 1957, with an increase in volume and a greater efficiency in the processing of claims, the unit claim cost has been reduced to $2.32.

In providing medical and surgical care to dependents of members of the armed services, the program has performed a useful service in an effective way. At first the dependents were not aware of the eligible benefits or how to apply for them. In an attempt to remedy this condition, the Department of Defense has released a booklet entitled *Medical Care for Service Dependents.*

Some areas have been involved in differences of opinion about the adequacy of certain fees. In this respect, New Jersey has been fortunate. The Medical Society of New Jersey and the Government administrators agreed upon a fee schedule that was believed to be an average of the charges by New Jersey physicians for their professional services. It was further agreed, however, that in no instance would the agreed upon fee be less than that provided by New Jersey's Blue Shield Plan for a particular procedure.

Provisions have been made for adjustments when a physician believes he is entitled to a fee higher than that permitted under the Schedule of Allowances. In such instances, the physician is requested to submit a special report to Medical Service Administration. This is referred to the Special Medicare Committee of The Medical Society of New Jersey for recommendation. After careful review, the Committee's recommendation is then returned to Medical Service Administration, which submits it with the physician's claim to the Federal Government for review and approval. The amount approved for payment to the physician is finally paid by Medical Service Administration.

We commend the members of the Special Medicare Committee of The Medical Society of New Jersey for their conscientious consideration of each case submitted for review and recommendation. With only a few exceptions, the Office of Dependents' Medical Care has concurred in the recommendations of the Committee.

At the beginning of the program, one-third of the claims received were returned to physicians for additional information because of incomplete or incorrect preparation of claim forms. Although this proportion of incomplete claims has been reduced, additional steps are being taken to eliminate the difficulties. The Federal Government is currently revising the basic claim form and clarifying instructions to physicians.

On June 28, 1957, The Medical Society of New Jersey and Medical Service Administration of New Jersey signed a Joint Renewal Contract with the Department of the Army, for the conduct of the Dependents' Medical Care Act, P. L. 569 in New Jersey until June 30, 1958.

Subsequently, Medical Service Administration, as Fiscal Administrator, renewed the subcontract with the Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration.

Medical Service Administration of New Jersey obtains official signatures on all documents and is responsible for their proper transmission; reviews and advises Hospital Service Plan on all questionable claims involving status of

CLAIM EXPERIENCE

		Returned	Paid		On Hand	In Process of Paymt.
Received	Declined	As Incomplete	Claims	Amount		
10,017	230	3,179	5,982	$489,265	536	of which 271

physicians, application of the Fee Schedule, or medical practice; reviews all correspondence between the Fiscal Administrator and the Special Medicare Committee and the Office for Dependents' Medical Care, and assigns members of its medical staff as required, to perform these services.

CONCLUSIONS

Medical Service Administration of New Jersey continues to demonstrate to The Medical Society of New Jersey its value and importance as an organization through which medical care may, by arrangements with government agencies at Federal, State or other levels, be made available to individuals and groups not eligible for insurance protection against illness on a non-profit voluntary prepayment basis, in a manner which preserves the patient-physician relationship and allows free choice of physician and patient.

Again, the Board of Governors of Medical Service Administration of New Jersey wishes to express to The Medical Society of New Jersey its appreciation of and thanks for the continued moral and financial support so generously given the Administration during the seventeen years of its existence.

Approved (page 397)

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

ROYAL A. SCHAAF, M.D., President, Board of Trustees

The completion of 15 full years of operation of the Medical-Surgical Plan of New Jersey on June 30, 1957 marked another milestone in the development of the Plan in its effort to meet the intention of the members of The Medical Society of New Jersey to provide adequate medical care for every person in the State of New Jersey on a prepaid insurance basis at premium rates within the means of most persons gainfully employed. Included in this report are many data which clearly set forth the present condition of the Plan in regard to its enrollment, its annual income, its disbursements to physicians, its utilization and other factors.

The financial stability and the efficiency of operation of the Plan are reason for congratulation and gratification to the members of The Medical Society of New Jersey, as well as to the Plan's Subscribers and the public at large.

At present the Plan is flourishing in all essential respects but it did not attain its present state of well-being without trials and tribulations—numerous, varied and difficult—in the course of our existence. However, most of our difficulties have been satisfactorily overcome but we are still not without problems.

Credit for the great success which has crowned the work of the Plan must be accorded to the loyalty and understanding of its Participating Physicians—the roster of whom now includes about 80 per cent of all eligible physicians who are available to render medical services to the sick, injured and disabled in our state.

The activities of the Medical-Surgical Plan's Field Representatives increased somewhat in 1957 over those in 1956. A principal feature of this program has been a schedule of visits to general hospitals throughout the State and the establishment of an information desk at the hospital on the day on which the visit has been scheduled. The purpose of the program is primarily to provide information as to claim procedures and reporting requirements of the Plan and to assist physicians in solving problems arising in the course of their individual dealings with the Plan.

During 1957, Medical-Surgical Plan made available to the entire population of New Jersey for the first time, enrollment on a non-group basis. The Plan, in 1950, had accepted a trial enrollment of a limited number of persons on a non-group basis for the purpose of studying its experience with that enrollment in order to formulate a permanent Contract and enrollment policy under which it might meet the acknowledged need for non-group enrollment.

The following data will cover most of the points which would be of interest or concern to the members of The Medical Society of New Jersey, as well as to the Plan's Subscribers.

COMPARATIVE STATEMENT (as of December 31)

ASSETS

	1957	1956
Cash	$ 767,278	$1,179,665
Accounts Receivable—Subscriptions	564,161	567,681
Accounts Receivable—Hospital Service Plan	284,647	162,405
Accounts Receivable—Other	15,026	38,897
Accrued Interest Receivable	133,643	55,530
Investments	11,907,392	7,536,148
TOTAL ASSETS	$13,672,147	$9,540,326

LIABILITIES

Payable for Medical-Surgical Claims	$ 3,750,000	$2,916,306
Unearned Subscriptions	1,114,246	875,417
Other Liabilities	29,084	22,797
TOTAL LIABILITIES	$ 4,893,330	$3,814,520

RESERVES FOR THE PROTECTION OF SUBSCRIBERS

Securities Evaluation	$ 100,000	$ —
Deferred Maternity Benefits (Jan. 1, 1957— 725,000)	1,553,000	725,000
Special Contingency (Jan. 1, 1957— 100,000)	100,000	100,000
Unassigned (Jan. 1, 1957—4,900,806)	7,025,817	4,900,806
TOTAL RESERVES	$ 8,778,817	$5,725,806
TOTAL LIABILITIES AND RESERVES	$13,672,147	$9,540,326

ENROLLMENT GROWTH

1942	4,131
1945	49,441
1948	236,604
1951	669,906
1954	1,196,804
1956	1,546,007
1957	1,711,834

Field Service Program during 1957

69 hospitals visited

1482 physicians contacted

17 of the 21 counties were covered under this program

Enrollment on a Non-Group basis

Subscribers enrolled only under Hospital Service Plan Subscription Contracts were solicited for Blue Shield enrollment.

Of the 23,600 applications received, 18,640 were approved.

Under a separate State-wide campaign, conducted through the combined facilities of radio, newspapers and direct mailings 11,676 applications were approved.

During both campaigns approximately 18 per cent of the applications were disapproved for one or more of the reasons stated:

Health conditions

Over age 65

Residence outside of New Jersey.

COMPARATIVE SUMMARY OF OPERATIONS

	1957		1956	
Subscriptions Earned	$27,900,952	100.0%	$22,423,453	100.0%
Less:				
Claims Incurred	$22,886,254	82.0	$18,960,672	84.6
Operating Expenses	2,401,044	8.6	2,172,733	9.7
	25,287,298	90.6	21,133,405	94.3
Gain from Underwriting Operations	$ 2,613,654	9.4%	$ 1,290,048	5.7%
Income on Investments	315,445		178,878	
Operating Gain for the Year	$ 2,929,099		$ 1,468,926	

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1	$ 5,725,806	$ 4,386,951
Operating Gain for the Year	2,929,099	1,468,926
	$ 8,654,905	$5,855,877
Plus: Change in Non-Admitted Assets	123,912	—
Less: Change in Non-Admitted Assets	—	130,071
Reserves at December 31	$8,778,817	$ 5,725,806

HIGHLIGHTS OF PLAN OPERATIONS 1957-1956

Subscriptions Earned by the Plan Increased in 1957 over 1956 by		$5,477,499
Subscribers Claims Incurred by the Plan Increased in 1957 over 1956 by		3,925,582
Operating Expenses Increased in 1957 over 1956 by		228,311
However, based on Subscriptions Earned, 1957 showed a percentage decrease of		1.1%
Reserves for the Protection of the Plan's Subscribers Increased in 1957 over 1956 as follows:		
Securities Evaluation	$ 100,000	
Deferred Maternity Benefits	828,000	
Unassigned	2,125,011	
		$3,053,011

CLAIMS INCURRED

1942	$ 5,395
1945	208,288
1948	1,203,652
1951	6,527,375
1954	13,991,592
1956	18,960,672
1957	22,886,253

INCIDENCE PER 1000 PERSONS

1942	40
1945	86
1948	96
1951	112
1954	126
1956	143
1957	157

Note: Because of insufficient data of earlier years average exposure for any year was of necessity defined as the average of the beginning and ending exposure of the year.

ANNUAL STATISTICS 1957

TABLE I

PAID 1957	Services				
	Primary Services	Total Services	% (All Services)	Payment	%
Surgical	130,186	157,252	39.7%	$11,087,767.15	50.4%
Medical	57,958	68,308	17.3	3,475,424.94	15.8
Obstetrical	41,536	43,203	10.9	5,002,248.20	22.7
Consultation	—	23,169	5.9	348,102.54	1.6
Anesthesia	—	86,013	21.7	1,806,892.22	8.2
Surgical Newborn	14,653	15,725	4.0	165,967.50	0.8
Medical Newborn	2,127	2,212	0.5	127,385.00	0.5
TOTAL	246,460	395,882	100.0%	$22,013,787.55	100.0%

TABLE II

AVERAGE PAYMENT PER PRIMARY SERVICE

(SERVICE)—PAID 1957

Surgical	$ 85.17
Medical	59.96
Obstetrical	120.43
Consultation	(15.02)
Anesthesia	(21.01)
Newborn	17.48

TABLE III

DISTRIBUTION PER DOLLAR OF INCOME

	Cents
Surgical	41.9
Obstetrical	18.6
Medical	13.4
Contribution to Reserves	9.4
Operating Expense	8.6
Anesthesia	6.8
Consultation	1.3

TABLE IV

Incurred 1957 Source: Controller's Office

Total Liability 1957	—	100.0%
Incurred Claims	—	82.0%
Operating Expense	—	8.6%
Contribution to Reserve	—	9.4%

Additional breakdown of incurred claims based on distribution of paid claims for 1957.

Total Payment 1957	$22,013,787.55	—	82.0%
Surgical	11,253,734.65	—	41.9
Medical	3,602,809.94	—	13.4
Obstetrical	5,002,248.20	—	18.6
Consultation	348,102.54	—	1.3
Anesthesia	1,806,892.22	—	6.8

Note 1: All lines shown in each table are mutually exclusive.

Note 2: Average payment for consultations and anesthesias are payment per service; payments for these services are not included elsewhere in the table.

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

COUNTY	Participating M.D.	Participating D.O.	Participating Total	Non-Participating M.D.	Non-Participating D.O.	Total Eligible Phys.	% P.P. as of 12/31/57	% P.P. as of 12/28/56
Atlantic	161	13	174	24	—	198	87.9	85.3
Bergen	499	31	530	251	2	781	67.6	67.8
Burlington	95	8	103	20	3	126	81.7	83.2
Camden	294	54	348	58	3	409	85.1	83.1
Cape May	44	6	50	6	—	56	89.2	87.5
Cumberland	86	3	89	7	1	97	91.7	91.3
Essex	1286	50	1336	260	9	1607	83.1	83.0
Gloucester	65	6	71	16	5	92	77.2	72.7
Hudson	549	8	552	146	1	700	78.9	79.5
Hunterdon	43	—	43	7	—	50	86.0	89.6
Mercer	326	4	330	54	5	389	84.8	86.6
Middlesex	247	4	251	52	1	304	82.6	82.2
Monmouth	244	14	258	65	2	325	79.4	82.5
Morris	190	8	198	51	4	253	78.3	79.0
Ocean	60	5	65	13	—	78	83.3	82.2
Passaic	412	10	422	123	—	544	77.4	77.0
Salem	44	5	49	4	—	53	92.4	90.0
Somerset	92	1	93	18	1	112	83.0	85.3
Sussex	31	1	32	9	1	42	76.2	78.9
Union	428	19	447	167	4	618	72.3	72.2
Warren	39	2	41	4	—	45	91.1	86.4
Out of State	121	6	127	—	—	127	—	—
Totals	5354	258	5602	1356	42	7000	80.0	80.0

Total Resigned since 1942 459
Total Resigned since 12/31/55 228
ReParticipating since 1942 104
ReParticipating since 12/31/55 85
Plus 128 Resignations—Moved Out of State

1957 BOARD OF TRUSTEES

Charles W. Barkhorn, M.D.	1952
Irving P. Borsher, M.D.	1950
Robert G. Boyd, M.D.	1957
Harry N. Comando, M.D.	1942
Patrick H. Corrigan, M.D.	1952
William F. Costello, M.D.	1948
Joseph P. Donnelly, M.D.	1953
Joseph I. Echikson, M.D.	1954
Joseph M. Keating, M.D.	1953
Arthur W. Lunn	1951
Paul Mecray, Jr., M.D.	1953
Duane E. Minard, Jr.	1957
Royal A. Schaaf, M.D.	1942
Rudolph C. Schretzmann, M.D.	1945
James H. Spencer, M.D.	1957
Edward W. Sprague, M.D.	1942
John S. Thompson	1942
Thomas J. White, M.D.	1951
Carl K. Withers	1952

ADVISORS TO THE BOARD OF TRUSTEES

		Term as Board Members
Samuel A. Cosgrove, M.D.	1953	1943-1953
William E. Dodd, M.D.	1952	1944-1952
Elton W. Lance, M.D.	1951	1942-1951

Note: Appointment Year Shown After Name.

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
*Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
*William J. Carrington, M.D.	1942-1943
William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
*Augustus S. Knight, M.D.	1942-1948
*Thomas K. Lewis, M.D.	1942-1949
*Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951

Deceased

It has been my happy privilege since the inception of the Plan to be closely associated with these colleagues, 31 in number, whose competence, loyalty, industry and devotion to the interests of the Plan have earned for them the appreciation of the physicians of New Jersey. It would be impossible to evaluate adequately the contribution that these men have made to the Blue Shield movement.

Although much has been accomplished much still remains to be done. Our staff is now working diligently in the effort to develop a new subscription contract as well as to perfect several riders to our present subscription contract which will include certain additional benefits which the House of Delegates of The Medical Society of New Jersey requested the Plan to provide, and which will also meet the demands of national accounts for extended coverage. The Trustees hope to have these riders approved by the Department of Banking and Insurance in the very near future. The Fee Committee has spent many hours of hard work during the past few months in reviewing the Schedule of Payments for the purpose of recommending selective increases where necessary or indicated. We have been unsuccessful hitherto in securing from the Department of Banking and Insurance approval of our proposal to eliminate from the present contract the provision under which prenatal care out of hospital is an eligible benefit. The Trustees hope to attain this most desirable objective when the next subscription contract is adopted.

I wish to acknowledge publicly the excellent service which the Hospital Service Plan of New Jersey has given to the Plan throughout its entire existence. The relationship between the Plans has never been closer or more cordial, and the efficient conduct of the details of our work, infinite in number, has contributed much to the success of our operation.

I wish also to express to our Medical and Administrative Staffs and to all our co-workers our lasting gratitude for the devoted service which they have tendered.

Approved (page 397)

REFERENCE COMMITTEE REPORTS

Reference Committee "A"

Mary Bacon, M.D., Chairman

Reference Committee "A" met on Sunday, May 18, 1958, at 11:00 a.m., in Room 1333, Haddon Hall. Members present were Drs. Jacob M. Schildkraut, Noah Meyerson, Harry N. Comando, Dorsett L. Spurgeon, and Mary Bacon, Chairman. This committee was assigned the duty of reviewing and considering the annual reports of the President, the Board of Trustees, the Secretary, the Judicial Council, and the Executive Officer.

President, Dr. Albert B. Kump (page 323)

The President's annual report was written a few days before his death. The report is routine, of the Society's accomplishments and achievements, of progress and objectives in many fields, brought about and to be brought about, by all who have labored and who will labor for the good of The Medical Society of New Jersey. But the committee feels, with our Executive Officer, that this was a year of greater significance than all that . . . A year of great enrichment for The Medical Society of New Jersey not only in terms of the services rendered to its aims and endeavors as an organization, but especially in terms of the good accruing to the souls of its members in consequence of the example of integrity, fortitude, constancy and valor which our President supplied. Albert Kump has shown with unmistakable impressiveness and with simple heroism how a great man lives and dies.

Adopted

Board of Trustees, Dr. Carl N. Ware, Chairman (page 327)

Reference Committee "A" next considered the report of the Board of Trustees. Dr. Carl N. Ware was elected Chairman, and the presidential burden was greatly lightened because of the loyalty of the Chairman and the able judgment and unstinted efforts of the entire Board. Carrying on the Society's business made heavy demands upon them. Board meetings were held at least monthly and were well attended . . . Each meeting requiring of each member the sacrifice of a personal day to the Society's work. Regularly the Board of Trustees has dealt with general matters brought to its attention; correspondence; and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of reports and recommendations of the several standing and special committees, including the Welfare Committee, its sub and special committees; cooperation with the State Department of Health in public health programs and with the State Department of Motor Vehicles on traffic matters. Three items from the actions of the 1957 House of Delegates were referred to special committees for study. They were 1st, Workmen's Compensation Testimony, which would involve a study of testimony in compensation courts on a statewide basis; 2nd, cooperation with the Division of Workmen's Compensation, State Department of Labor and Industry, for the purpose of improving the quality of medical testimony; and, 3rd, formulation of codes of standards of practice governing lawyers and physicians.

Meetings have been held with the Commissioner of Labor and Industry and the Director and Deputy Director of the Division of Workmen's Compensation. Further meetings with representatives of the Department and the Division are necessary.

Special and more intricate concerns of the Board of Trustees, up to eighteen or more, have been referred to other appropriate and diverse reference committees for individual deliberation and report to this House—such matters as Short-term Investments; Medicare Program; Hospital Medical Services; Medical-Surgical Plan; Medical Service Corporations, Participating Physicians; Medical Service Administration; False Complaints; Corporate Practice of Medicine; English as a Factor for Medical Licensure; Veterans Administration Contract; Asian Influenza; Classified Telephone Directory Listings; Examination of Hospital Records; on and on ad infinitum.

Time permits in this report only the highlights of the work of the Board of Trustees. After studying their Chairman's report, this committee found itself consulting memories and THE JOURNAL to see just who these men were who gave this time and effort to problems that may well be more important to some of us than to individual members of the Board of Trustees. The Board of Trustees comprised, in addition to our deceased President, Dr. Carl N. Ware, Chairman; whose task was made more difficult by his personal loss; Dr. Louis S. Wegryn, Secretary; Dr. Kenneth E. Gardner; Dr. F. Clyde Bowers; Dr. Jesse McCall; Dr. Marcus H. Greifinger; Dr. Rudolph C. Schretzmann; Dr. Lewis C. Fritts; Dr. David B. Allman; Dr. C. Byron Blaisdell; Dr. Ralph M. L. Buchanan; Dr. Joseph P. Donnelly; Dr. Lloyd A. Hamilton; Dr. Luke A Mulligan; Dr. Royal A. Schaaf; Dr. Reuben L. Sharp; and Dr. L. Samuel Sica.

We commend and thank Dr. Carl N. Ware and the Board of Trustees for their interest in The Medical Society of New Jersey and the personal sacrifices required to accomplish this work so necessary and so important to all members.

Adopted

Secretary, Dr. Marcus H. Greifinger (page 324)

The office of the Secretary deals each year with a mounting volume of routine matters as The Medical Society of New Jersey becomes more comprehensive in its activities. In addition, Dr. Greifinger attended the annual meeting of the American Medical Association in New York and the mid-winter meeting in Philadelphia, as well as each meeting of the Board of Trustees and multitudinous committee meetings, of which he was either chairman, advisor, or member.

He reports a total of active members of The Medical Society of New Jersey of 5,952, with 263 associate members. Our delegation to the American Medical Association continues to be six in number, based on the allocation of one delegate to each one thousand members or fraction thereof.

The 1957-58 *Membership Directory*, the third issue of the publication, was mailed the first week in November, listing all members reported to the Executive Offices as of June 1, 1957.

Reference Committee "A" recognizes the enormous amount of time and effort expended by the Secretary, Dr. Marcus H. Greifinger, and the executive and clerical help of the Edith L. Madden staff, and expresses for the Society thanks for the year of service together with the annual report.

Adopted

Judicial Council, Dr. Daniel F. Featherston, Chairman (page 335)

Apart from its work as an appellate tribunal, considering matters originally dealt with by county judicial committees, the Judicial Council has the responsibility of supervising, directing, and keeping records of all complaints dealt with by county judicial committees as matters of original jurisdiction. The Council receives reports of all cases accepted for adjudication by county judicial committees and of the disposition made of them.

In accordance with the precedent of other years, the Judicial Council has presented as an appendix to its report the three opinions which it issued in the course of the administrative year. Your committee recommends these opinions to the perusal of the members of The Medical Society of New Jersey. Following is the list of their subject matter:

1) Concerning the ethical acceptability of a doctor's testifying on a contingency basis

2) Concerning the ethical acceptability of a surgeon's paying a surgical assistant a portion of the fee received from an insurance carrier

3) Concerning the ethics involved in adoption proceedings.

Other operations of the Council for the year ending March 31, 1958 were as follows: one appeal hearing before the Judicial Council of the American Medical Association; nine appeal hearings at state level; receipt of fifty-one reports of complaints disposed of at county level, with eleven still pending.

Our committee should like to pay tribute to Dr. Featherston and his Council-members for the constancy and the efficiency with which they have fulfilled their responsibilities throughout the year. We commend them, together with their and our Legal Counsel, and also the Executive Officer—both of whom have lent assistance to Dr. Featherston as required, for efficient operation of the Council.

Adopted

Executive Officer, Richard I. Nevin (page 338)

Mr. Nevin, in his annual report, pays this beautiful tribute to our late President, Dr. Albert B. Kump:

"Such was the valor of his spirit, such the uncompromising character of his sense of responsibility and duty, that never did he make the least concession to his physical condition. Instead, with disciplined intensity, he held himself to his work for his colleagues and his fellowmen until his body could no longer respond to the demands of his indomitable spirit."

The Executive Officer's year has been one of intense activity and constantly accelerating tempo. New services are called for and new demands are being made. In conjunction with them new problems arise that call for ingenuity, patience, and industry on the part of our Executive Officer. Committees have been more numerous; contacts many and growing; conferences have been more protracted.

Your committee calls the attention of the membership especially to the addendum to this report which the Executive Officer has supplied, "The Medical Society of New Jersey in Action." In this summary of the Society's activities we have an informative and enlightening compilation which, your committee feels, each member will want frequently to consult. To this end your committee recommends that the resume be published by the Subcommittee on Public Relations in an early issue of the *Membership News Letter*, and that it be prepared in a compact form for distribution upon request to our membership.

Our Executive Officer recognizes two great purposes toward which all the efforts of The Medical Society of New Jersey are being bent: (1) the improvement of the standards and quality of medical care, and (2) the preservation of our form of government and our way of life.

This year the Executive Offices handled more than 190,000 pieces of mail. The Executive Officer has participated in 171 meetings and conferences, and filled fourteen speaking engagements and made four trips out of state on special commissions. He has also corresponded, advised, composed, edited, explained, placated, and directed!

We commend our Executive Officer and recommend the adoption of this portion of our report.

Adopted

The Chairman genuinely appreciates and acknowledges the help of a very excellent committee, comprising Drs. Schildkraut, Meyerson, Comando, and Spurgeon, and moves the adoption of the report of Reference Committee "A" as a whole.

Adopted as a whole

Reference Committee "B"

Jesse McCall, M.D., Chairman

Reference Committee "B" met at 11:00 a.m., Sunday, May 18, 1958 in room 1344, Haddon Hall. All members were present. For consideration by the committee the following items were presented: Annual Reports of Treasurer, including an item from the Board of Trustees, re Short Term Investments; Finance and Budget Committee; Publication Committee; Medical Student Loan Fund Committee, including a supplemental report.

Treasurer (pages 325 and 328)

The report of the Treasurer was reviewed in detail and its adoption, as presented, is recommended to this body. The attention to duty and responsibility of Dr. Schretzmann, as reflected in the excellent financial condition of the Society is highly commended. Dr. Schretzmann reported that due to a tendency to instability of the market during the past year, he had been unable to reconcile good financial judgment, and our fluctuating surplus funds, with short term investments. The committee recommends that he continue to explore the advisability of short term investments, if and when the checking account justifies that procedure.

Adopted

Finance and Budget Committee (page 340)

Your reference committee studied in detail the report of this important committee and recommends its adoption as presented.

The committee feels it necessary to call to the attention of the House of Delegates certain points in regard to the contribution of $15,000 to A.M.E.F.

There was considerable discussion as to the procedural propriety of the Board of Trustees' giving this additional grant after the House of Delegates had voted only an amount of $10,000. It was felt by some members of the reference committee that the Board of Trustees had exceeded its bounds in making this grant. However, the committee was unanimous in agreeing that the donation was for a commendable cause, and we further agreed that: 1) The 1957 House of Delegates approved the budget of 1957-58, containing the item D-8—A.M.E.F. —$25,000; 2) That the Finance and Budget Committee of last year did recommend that our contribution be $10,000 in fact (not budget) in an effort to reconcile a bookkeeping differential between our fiscal year methods and the calendar year methods of the A.M.E.F.; 3) That the coincidence of excellent financial status of the Society, and the occupancy of the presidential chair of the A.M.A. by Dr. David B. Allman, pointed up the propriety of a one-time supplemental grant of $15,000 to a most worthy cause—A.M.E.F.; 4) That the $15,000 still kept the disbursement of funds within the budgetary allotment approved by the 1957 House of Delegates.

In connection with the proposed reduction in dues for the Society membership, the committee shares with the general membership the expected feeling of relief. We offer, however, for your serious reflection, the thought that the normal wishes of every member of The Medical Society of New Jersey to maintain his participation in such worthy projects as A.M.E.F. and the Medical Student Loan Fund of our own Society, will undoubtedly require appropriate dues increases throughout the coming years.

We therefore concur in the recommendations of the Finance and Budget Committee as follows: 1) That the 1958 contribution to the A.M.E.F. be in the amount of $25,000; 2) That the budget for 1958-59 be adopted in the sum of $193,299; 3) That the 1959 assessment be $30 per capita.

Adopted

Publication Committee (page 342)

Your committee recommends the adoption of this report as presented.

We would be remiss, however, if we did not, at least for a moment focus your attention on the credit to The Medical Society of New Jersey which The Journal brings. Editorial and economic soundness are often hard to achieve simultaneously in any publication. That both of these virtues are demonstrated in our Journal is largely due to the work of Dr. Davidson and Mrs. Armstrong.

Adopted

Medical Student Loan Fund (page 359)

Your committee recommends the adoption of this report as presented. This includes the supplemental report presented to the House of Delegates by Dr. Bowers on Saturday afternoon, May 17, 1958.

The committee commends the work of the chairman of the Medical Student Loan Fund in these early days of its growth and development. It urges that he seek continued contacts with component societies encouraging individual and group contributions, on a voluntary basis, to this most worthy project.

Adopted

A. M. E. F. (page 341)

Recommend that The Medical Society of New Jersey make a contribution of $25,000 to the American Medical Education Foundation for 1958.

Adopted

Adopted as a whole

Reference Committee "C"

Frederick W. Durham, M.D., Chairman

Reference Committee "C" met at 11:00 a.m., May 18, 1958, with Drs. John F. Kustrup, John L. Olpp, Charles A. Landshof, and John J. Laurusonis present. The Chairman is deeply appreciative of their excellent collaboration in the formation of this report. A number of the issues were spiritedly debated by many of the seventy-odd members in attendance.

The following actions were taken:

Medical Service Administration of New Jersey (page 387)

The annual report is approved as submitted. The reference committee commends the work of the Medical Service Administration, especially for its efforts in the formative planning of Medicare.

Adopted

Nominations to Board of Governors, Medical Service Administration (page 331)

The nominations as presented are approved.

Adopted

Special Committee on the Medicare Program (item from Board of Trustees) (page 328)

The reference committee recognizes and approves the work of this committee.

Adopted

Medical-Surgical Plan of New Jersey (page 389)

This report is approved, and the reference committee commends the continued sagacity of the Medical-Surgical Plan Board of Trustees.

Adopted (A motion from the floor to delete the second phrase of the reference committee report was lost.)

Hospital Medical Services (item from Board of Trustees) (page 328)

This item received no action because the results of the study were referred to Reference Committee "E".

Adopted

Items from the Board of Trustees re *Medical-Surgical Plan* (page 328)

1. *Contract Inequities*—This report by the Board of Trustees is a summary of the conclusions of the Conference of the Permanent Committee on Blue Shield and of The Medical Society of New Jersey, and represents a reply to a resolution adopted by the 1957 House of Delegates. Lively discussion was given this issue by the membership present at the reference committee meeting.

The report is approved with the following recommendation: That the legal counsel of The Medical Society of New Jersey be requested for an opinion on the items relating to multiple Medical-Surgical type coverage and income classification.

Second paragraph amended to read: The report is approved with the following recommendation: That legal counsel of The Medical Society of New Jersey be requested for opinion on items relating to multiple medical-surgical type coverage, third-party liability, and income classification with respect to recommending to the Blue Shield Board of Trustees the inclusion of these items in the present contract; if it is not possible, then these items are to be included in any type of contract subsequently issued.

Adopted as amended

2. *Physician Lists* (page 329)—This item is approved.

Adopted

3. *Board of Trustees* (page 329)—The nominations as presented are approved.

Adopted

4. *Two Level Contract* (page 329)—This item is approved.

Adopted

5. *Home Care Benefits* (page 329)—This item is approved.

Adopted

6. *Medical-Surgical Plan Policies* (page 329) – This report is approved with the following suggestion: that the words "that this, or a similar committee be continued by the Board of Trustees of The Medical Society of New Jersey to" be changed to "that the Permanent Committee on Blue Shield." This alteration would occur in (2) under the committee's recommendations.

Adopted

The reference committee also makes the additional recommendation that the following be added to the report: The chairman or a member of each county Medical-Surgical Plan Committee meet with the Permanent Committee on Blue Shield in sufficient time prior to the annual meeting of the House of Delegates to discuss all unsolved prob-

lems and potential or possible resolutions applicable to the Medical-Surgical Plan.

Adopted

7. *Chiropodists and Dentists* (page 330)—This item is approved.

Adopted

8. *Medical Service Corporations - Participating Physicians* (page 330)—The reference committee approves this policy.

Adopted

Resolutions

1. *Medicare Program* (from Bergen County (page 378)

The reference committee approves this resolution. Attention is called to the annual report of the Medical Service Administration of New Jersey.

Adopted

2. *Medical Fees — Medical-Surgical Plan* (from Bergen County) (page 378)

This resolution is approved with the recommendation that the following changes in wording of the fifth paragraph be made:

Whereas, "the internist and general practitioner treating serious illness have frequently noted insufficient recompense" be substituted for "it is obvious that the internist and general practitioner treating serious illness are unfairly treated"; and also in the final paragraph substitute the word "inequity" for "injustice."

Adopted

The reference committee directs attention to recent increased benefits enacted by Medical-Surgical Plan.

Adopted

3. *Medical-Surgical Plan—Income Limit Regulations* (from Hudson County) (page 379)

This resolution is approved.

Adopted

4. *Medical-Surgical Plan and Additional Coverage* (from Hudson County) (page 379)

The substance of this resolution was considered in the report of the Conference of Permanent Committee on Blue Shield and The Medical Society of New Jersey on July 30, 1957, and also previously considered in prior items of this report. The reference committee recommends disapproval of this resolution.

Last sentence amended to read: The reference committee recommends that the resolution be not adopted because favorable action has been taken on the subject by previous action of the House today.

Adopted as amended

5. *Medical-Surgical Plan and Additional Coverage* (from Passaic County) (page 379)

The intent of this resolution has been considered in the report of the Conference of the Permanent Committee on Blue Shield and The Medical Society of New Jersey. The reference committee disapproves Item 1, and has made previous recommendation for advice of counsel covering Item 2.

Last sentence amended to read: The reference committee has made recommendation for advice of counsel covering item 1 and item 2.

Adopted as amended

6. *Medical-Surgical Plan—Contract Inequities* (resubmission of resolution by Middlesex County) (page 380)

The reference committee feels that the contents of this resolution and its excellent attached discussion have previously been studied. The reference committee recommends disapproval of this resolution. We call attention, however, to the fact that favorable action was taken on Items 1 and 2, which are being referred to legal counsel.

Last two sentences deleted and the following substituted: The reference committee recommends approval of those portions of the resolution, items 1, 2, and 3, which are being referred to legal counsel for opinion as previously approved by the House.

Adopted as amended

7. *Surgical Care of Patients with Facial and Jaw Injuries—Medical-Surgical Plan* (from Warren County) (page 381)

The reference committee disapproves this resolution. It is to be noted that the dentists are not legally eligible for participation in the Medical-Surgical Plan of New Jersey.

Report amended by the addition of the following sentence: It is the position of this Society that the appropriate method for the provision of insurance plans covering the services of those other than Doctors of Medicine is the enactment of enabling legislation for the establishment of plans independent of medical care specifically covering the services of the professional or occupational groups concerned.

Adopted as amended

8. *Blue Cross Inter-Plan Service Bank* (from Union County) (page 382)

The reference committee approves this resolution with the recommendation that the Blue Cross be invited to submit for publication in THE JOURNAL of The Medical Society of New Jersey the clarifying details of this Inter-Plan Service Bank.

Adopted

Adopted as a whole as amended

Reference Committee "D"

Louis K. Collins, M.D., Chairman

The entire committee consisting of Dr. Barbour, Dr. Johnson, Dr. Cox, Dr. Silverman, and Dr. Collins, chairman, met at 11:00 a.m., Sunday, May 18, 1958, and considered the following reports: Medical Education Committee; Medical Defense and Insurance Committee; Physicians Placement Service; Special Committee on Widows and Orphans of Medical Men; Special Committee on Traffic Safety; Item from the Board of Trustees on False Complaints; a Resolution on Atomic Warfare, submitted by the Cumberland County Medical Society; and a Resolution on Retirement Plan for Physicians, submitted by the Mercer County Medical Society.

Medical Education Committee (page 345)

The reference committee approved the report as submitted.

Adopted

Medical Defense and Insurance Committee (page 342)

With the approval of the chairman of the Medical Defense and Insurance Committee, the report was amended on the third page by changing the word "extent" to "minimum"—the amended wording to read, "that every member should protect himself to the minimum of $50,000/$150,000 limits." The reference committee approved the entire report of the Medical Defense and Insurance Committee as amended, and would like to commend Dr. Hurff and his committee for a job well done.

Adopted

Physicians Placement Service (page 360)

The report was approved as submitted.

Adopted

Special Committee on Widows and Orphans of Medical Men (page 361)

The report was approved as submitted.

Adopted

Special Committee on Traffic Safety (page 360)

The report was approved as submitted, and we wish to commend the committee on its excellent work and plans for the future.

Adopted

False Complaints (Item from the Report of Board of Trustees) (page 331)

The item on False Complaints was approved as presented.

Adopted

Atomic Warfare Resolution (from the Cumberland County Medical Society) (page 382)

This resolution was disapproved for the following reasons:

1. The suggestions are already part of the United Nations' deliberations, and are also the national policy of our administration.
2. Responsible persons are already handling the problem.

The reference committee approved the spirit of the resolution and the intent of world abolition of atomic warfare.

Adopted

Retirement Plan for Physicians Resolution (from the Mercer County Medical Society) (page 383)

This resolution was disapproved as written. The reference committee did approve the spirit and intent of the resolution; and recommends that such a committee, as advocated in the resolution, be appointed to thoroughly investigate the problem, and further, that the report of said committee be published in THE JOURNAL of The Medical Society of New Jersey at least one month prior to the 1959 Annual Meeting.

Adopted

Adopted as a whole

Reference Committee "E"

Sherman Garrison, Jr., M.D., Chairman

Reference Committee "E" met at 11:00 a.m., May 18, 1958, with all members present. The following actions resulted from consideration and discussion of the reports and resolutions referred to this committee:

Welfare Committee (page 348)

The report of the Welfare Committee was approved as presented.

Adopted

Subcommittee on Legislation (page 350)

The report of the Subcommittee on Legislation was approved as presented.

Adopted

Subcommittee on Medical Practice (page 351)

The report of the Subcommittee on Medical Practice was approved as presented.

Adopted

Subcommittee on Public Health (page 352)

The report of the Subcommittee on Public Health was approved as presented.

Adopted

Subcommittee on Public Relations (page 353)

The report of the Subcommittee on Public Relations was approved as presented.

Adopted

Special Committee on Cancer Control (page 349)

The report of the Special Committee on Cancer Control was approved as presented.

Adopted

Special Committee on Chronically Ill (page 356)

The report of the Special Committee on Chronically Ill was approved as presented.

Adopted

Special Committee on Conservation of Hearing and Speech (page 356)

The report of the Special Committee on Conservation of Hearing and Speech was approved as presented.

Adopted

Special Committee on Conservation of Vision (page 357)

The report of the Special Committee on Conservation of Vision was approved as presented.

Adopted

Special Committee on Maternal and Infant Welfare (page 350)

The report of the Special Committee on Maternal and Infant Welfare was approved as presented.

Adopted

Special Committee on Mental Health (page 357)

The report of the Special Committee on Mental Health was approved as presented.

Adopted

Special Committee on Rehabilitation (page 358)

The report of the Special Committee on Rehabilitation was approved as presented.

Adopted

No Reports Received—The reference committee noted the fact that no reports were received from the following special committees: Industrial Health, School Health, and Workmen's Compensation.

Physical Examination of School Children—Resolutions (page 384)

The resolution on physical examination of school children, received from the Bergen County Medical Society, was approved in principle, and the committee recommends that it be forwarded to the Subcommittee on Legislation for action.

The resolution on physical examination of school children, presented to the House of Delegates by the Essex County Medical Society, was approved on the same basis as the Bergen County Medical Society resolution.

Adopted

Operating Room Training of Student Nurses—Resolution (page 385)

The resolution from the Mercer County Medical Society on operating room training of student nurses was approved as submitted.

Adopted

Examination of Hospital Records—Resolution (page 385)

The committee approved the intent of the Middlesex County Medical Society resolution on examination of hospital records, but in the interest of clarification recommends the amendment of the resolution by the deletion of the words "or by his treating physician," and the addition of the words "or incompetence," as follows:

Resolved, that Chapter 286 of the Laws of 1945, R. S. 2A:82-41 et seq. be amended to allow for

examination of hospital records only upon the consent, in writing, of either the patient against whom or by or for whom a claim is asserted for personal injuries or death resulting either under the Workmen's Compensation Act of the State of New Jersey, Chapter 15 of Title 34 of the Revised Statutes, or at law (delete: "or by his treating physician") or in the event of the death *or incompetence* of the said patient, then by his legal representative, or in lieu thereof by an appropriate order of a Court of proper jurisdiction, and be it further

Resolved, that a copy of this Resolution be presented to The Medical Society of New Jersey for action.

Adopted

The following items from the report of the Board of Trustees were considered:

1. The report on *Principles of Approach to Specialty Services* (page 331) was approved as submitted.

Adopted

2. The report on *Corporate Practice of Medicine* (page 331) was approved as submitted.

Adopted

3. The report on *English as a Factor for Medical Licensure* (page 332) was approved as submitted.

Adopted

4. The report on *Doctors of Osteopathy* (page 332) was approved as submitted.

Adopted

5. The report on *Intravenous Medications* (page 332) was approved as submitted.

Adopted

6. The report on *Veterans Administration Contract* (page 332) was approved as submitted.

Adopted

7. The report on *Asian Influenza* (page 333) was approved as submitted.

Adopted

8. The report on *Nursing Assistants* (page 333) was approved as submitted.

Adopted

9. The committee approved the report on *Classified Telephone Directory Listings* (page 333) and recognized the continued existence of this problem.

Legislation is under consideration at this time regarding the use of the M.D. degree.

The committee recommends that the sponsors of the original resolution consider the possibility of a resolution authorizing each county society to purchase space in the classified section of the telephone directory for the listing of names of members of the county medical society in each community.

Adopted

10. The committee approved the report on the *Blood Bank Commission* (page 334) as submitted.

Adopted

11. In view of the previous action of this House on the resolution from Middlesex County Medical Society on *Examination of Hospital Records* (page 334) the reference committee recommends further consideration of this resolution by the Board of Trustees.

Adopted

Adopted as a whole

Reference Committee on Resolutions and Memorials

Nicholas A. Bertha, M.D., Chairman

The Reference Committee on Resolutions and Memorials met at 11:00 a.m., May 18, 1958. Present were Drs. Bertha, Pettit, and Campbell; Dr. Bornstein excused; Dr. Gadek absent.

The nominations for emeritus membership (page 346) were reviewed and, upon motion by Dr. Pettit, seconded by Dr. Campbell, the nominations were approved unanimously.

Adopted

There were no nominations for honorary membership. (page 348)

Motion for adjournment, 11:30 a.m.

Adopted as a whole

Reference Committee on Miscellaneous Business

George G. Green, M.D., Chairman

The full membership of the Reference Committee was present at the meeting held May 18, 11:00 a.m., Haddon Hall.

Advisory Committee to Woman's Auxiliary (page 347)

The report of the Advisory Committee to the Woman's Auxiliary was unanimously accepted with commendation and appreciation for the work and enthusiasm of all the members.

Adopted

Annual Meeting Committee (page 346)

The report of the Annual Meeting Committee was unanimously accepted with commendation for the effort and organization that has been achieved.

Adopted

Scientific Exhibit Committee (page 346)

The report of the Scientific Exhibit Commit was unanimously accepted with commendation all concerned.

Adopted

Scientific Program Committee (page 347)

The Scientific Program Committee report w unanimously accepted with commendation. App ciation was expressed for the work involved rotating the days of the various meeting dat In this way no one group will always have t last afternoon session which is frequently poo attended.

Adopted

Adopted as a whole

Reference Committee on Constitution and By-Laws

Lorrimer Armstrong, M.D., Chairman

Reference Committee on Constitution and By-Laws met on May 18, 1958. Those present were: Drs. Sacks-Wilner, Jehl, Thompson, Marchione, and Armstrong.

Constitution (page 375)

The revision, which had its first reading in the House of Delegates at the Annual Meeting of The Medical Society of New Jersey in 1957, was first considered. The Reference Committee unanimously voted that the Constitution be accepted as recommended in 1957.

Adopted

By-Laws (page 361)

The revision of the By-Laws through current Chapter VII, and proposed revised Chapter VIII, was the extent of the work which the Committee on Revision of the Constitution and By-Laws presented for consideration.

There follows a copy of the proposed revision of the By-Laws with further recommended revisions from the Reference Committee—these revisions do not change the intent or purpose of the original proposals but merely clarify. All these recom mended revisions were agreeable to and accept by the Committee on Revision of Constitution a By-Laws.

The following revision was read and adopt section by section, chapter by chapter, and as whole

[Those words in brackets are recommended deletions].

Those words which are underlined are recommended revisions.

BYLAWS

CHAPTER I—MEMBERSHIP

Section 1—Composition

The membership of The Medical Society of N Jersey shall be as established by Article IV the Constitution. When not designated by a qua fying word—such as associate, emeritus, etc.—t term member or membership shall refer to [activ those members having full privileges, including t right to vote and hold office.

Section 2—List of Members

(a) Five (5) days before the first of March the treasurer of each component society shall forward to the Treasurer of this Society, a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assessment covering such membership.

(b) Not later than the first day of March in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deccased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(c) Immediately after Decemher 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date; at the same time indicating existing vacancies in the delegation, as defined by Article IV of the Constitution. Associate membership shall not be included in such computation.

(d) Not later than the first day of April in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

Section 3—Ineligibility

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster, shall be entitled to any of the rights or privileges of this Society until relieved of such disability. Nothing in the foregoing shall affect the right of appeal as set forth in Chapter VII of these Bylaws.

Section 4—Rules of Conduct

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of [the] members in all categories of The Medical Society of New Jersey in their relations to each other and to the public.

CHAPTER II—MEETINGS

Section 1—Annual Meeting

An annual meeting shall be held as provided in Article VIII of the Constitution at a time and place fixed by the House of Delegates or the Board of Trustees.

Section 2—Special Meetings

Special meetings of this Society or of the House of Delegates shall be called by the President upon the request of the Board of Trustees, or upon the petition of at least five percent (5%) of the membership of this Society representing at least ten percent (10%) of the membership of each of four (4) or more component societies.

Section 3—Rules of Order

The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order, Revised," when not in conflict with the Constitution and Bylaws.

Section 4—Registration and Identification

Each delegate and member in any category in attendance at an annual or special meeting of this Society shall [print his name and address on] properly complete an official registration card which he shall present at the registration desk. Failing to do so, he shall be considered absent. Upon verification by the Reference Committee on Credentials of his right to register, he shall receive a certificate or badge designating his status.

CHAPTER III—GENERAL SESSIONS AND SECTION MEETINGS

Section 1—General Sessions

All registered members may attend and participate in the proceedings and discussions of the general sessions and section meetings. Upon invitation other registrants may attend. The general sessions shall be for the presentation of the addresses of the President, President-Elect, invited guests, and scientific papers and timely discussions, as provided in the official program. These sessions shall be presided over by the President, President-Elect, or one of the Vice-Presidents.

Section 2—Section Meetings

(a) Section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided in the program. These section meetings shall be under the guidance of a presiding officer chosen by each section at its [last session] preceding meeting.

(b) At a regularly scheduled section meeting committees may be established for scientific investigations of special interest or of importance to the profession or public. No expense to this Society shall be incurred in connection therewith unless authorized by the House of Delegates and approved by the Board of Trustees.

Section 3—Length of Addresses

No address or paper, with the exception of those delivered by the President, President-Elect, and invited guest speakers, shall take more than twenty (20) minutes for presentation; and no discussor shall speak longer than five (5) minutes, nor more

than once, on any subject, unless by permission of the presiding officer.

Section 4—Ownership of Papers

All papers and reports presented to this Society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in THE JOURNAL of this Society or in other medical journals may be granted by the Committee on Publication.

Section 5—Guests

Upon invitation extended by this Society or any of its members, any person may become a guest during the annual meeting. Physician guests are entitled to attend the general session and section meetings. Non-physician guests may attend the general session, but may attend a section meeting only with the permission of the presiding officer of that section.

CHAPTER IV—HOUSE OF DELEGATES

Section 1—Meetings

(a) The House of Delegates shall meet on the first day of the annual meeting of this Society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general sessions and section meetings. Unless otherwise ordered by the House of Delegates, all its sessions shall be in [Executive Session] closed session. Closed session shall include officers, delegates, registered members, and guests invited by the Chair.

(b) The annual meeting of the House of Delegates shall consist ordinarily of three (3) sessions. Except as otherwise provided, the principal business of these sessions shall be: First Session: presentation of annual reports, introduction of resolutions, introduction of new business, and assignment of same to reference committees; Second Session: report of Nominating Committee and election; Third Session: presentation of and action upon reports of reference committees, unfinished business, and inauguration of newly elected officers.

(c) Consent of two-thirds (⅔) of the delegates present and voting shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Finance and Budget Committee. All new business so presented shall require a three-fourths (¾) affirmative vote of the delegates present and voting for adoption of new business so presented.

Section 2—Credentials

Each delegate shall present to the Reference Committee on Credentials a certificate bearing the Seal of this Society and the signature of its Secretary. A delegate will not be permitted to register or sit as a member of the House of Delegates: (1) without such certificate, (2) if his assessment has not been paid, or (3) if his component society has not paid its annual per capita assessment.

Section 3—Quorum

A quorum shall consist of at least ten percent (10%) of the membership of the House of Delegates representing at least ten percent (10%) of the delegation of each of seven (7) component societies.

Section 4—Voice, Vote, and Discussion

(a) Only members of the House of Delegates shall have the right of vote. The privilege of voice may be extended by the House, at its discretion to [invited] other members and guests.

(b) The presiding officer, with the consent of the House of Delegates, shall be empowered to limit discussion.

Section 5—Authority

The House of Delegates shall have the power to:

Prescribe the duties of its officers and its members, fix their compensation, if any;

Assess from time to time an annuity upon the component societies in the ratio of their membership respectively;

Adopt such rules and regulations for the due management of this Society and the several component societies as may be deemed necessary;

Issue charters to county societies applying for affiliation with this Society;

Revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws, upon the recommendation of the [Board of Trustees] Judicial Council.

CHAPTER V—PROCEDURE OF ELECTION

Section 1—Nominating Committee

(a) Each component society shall elect, at any meeting prior to March 31st of the fiscal year one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary at the close of the first session of the House of Delegates at the annual meeting.

(c) The Immediate Past-President of this Society shall be the member of the Nominating Committee representing the Fellows. If he shall not be able to serve, then at the close of the first session of the House of Delegates, the Fellows shall elect one of their number to be a member of the Nominating Committee. He shall forthwith present his credentials to the Secretary.

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations [containing nominations] for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

Section 2—Procedure of Nomination

(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.

The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.

(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.

(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.

The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.

The chairman shall have only the right to vote in case of a tie.

The secretary shall announce the result upon completion of each roll call. If the tabulation of any roll call be challenged by any member of the committee, the roll shall be called again. A majority vote of the members present shall nominate. In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. The call of the roll shall be repeated until a nomination is made.

(d) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.

(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

Section 3—Report and Election

(a) The report of the Nominating Committee, the submission of nominations from the floor by members of the House of Delegates—if any—and the election shall constitute the principal business of the second session of the House of Delegates.

(b) All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

(c) In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. Balloting shall be repeated until an election is made.

(d) The President-Elect shall advance to the office of President without process of nomination and election.

CHAPTER VI—RIGHTS AND DUTIES OF OFFICERS

Section 1—The President

The President shall preside at all meetings of this Society and at all sessions of the House of Delegates, unless he shall have appointed a Speaker as provided in Article V of the Constitution.

He shall appoint committee members as provided in these Bylaws, and he shall be an ex-officio member of all committees except the Nominating Committee.

He shall be the official spokesman of this Society, and shall perform such other duties and functions as custom and parliamentary usage may require.

Section 2—The President-Elect and the Vice-Presidents

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties and functions.

In the absence or disability of the President, his duties and functions shall devolve upon the other presidential officers in the order of their seniority.

In case of vacancy in the office of President, by death, resignation, or removal, the President's functions and duties shall devolve upon the other presidential officers in the order of their seniority. Such service on the part of a presidential officer [as Acting President] for a partial term as President shall not affect or diminish the regular presidential tenure.

Section 3—The Secretary

The Secretary shall be the official custodian of the Constitution and Bylaws and of the records of this Society and its House of Delegates.

He shall attend all annual or special meetings of this Society and all sessions of its House of Delegates; and he shall keep proper records thereof.

He shall issue official notice of all meetings, annual or special, of this Society or of its House of Delegates.

He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the component societies, a list of their representatives in the House of Delegates and on the Nominating Committee, as provided in Chapter I of these Bylaws, and shall publish such lists as

the House of Delegates or Board of Trustees may direct.

He shall require and receive from the secretaries of the component societies, a list of their officers immediately following election, and a list of their committee chairmen.

He shall be the sole custodian of the Official Seal of this Society and shall affix it to such documents as the Bylaws may require, or the House of Delegates, the Board of Trustees, or the President may direct.

He shall conduct such formal official correspondence in the corporate name of this Society as the House of Delegates, the Board of Trustees, or the President may direct.

He shall submit to the House of Delegates an annual report of the work of his office.

He shall furnish to the Board of Trustees or the President such information as may be necessary for this Society's business.

He shall perform such other functions as are specified in the Constitution and Bylaws.

He shall be entitled to reimbursement for expenses incurred in fulfillment of duties imposed by the Bylaws, or authorized by the House of Delegates or the Board of Trustees.

Section 4—The Treasurer

The Treasurer shall be under bond, at the expense of this Society, in such amount as may be required by the Board of Trustees.

He shall demand and receive all funds due this Society, and shall preserve all funds of this Society.

He shall receive bequests and donations, and maintain a complete record thereof.

He shall not pay money out of the treasury except (1) in amounts as provided in the annual budget, upon voucher of the officer or committee responsible for the expenditure, or (2) in amounts as provided by resolution of the Board of Trustees and for which a voucher has been prepared. All such vouchers shall be approved and signed by the chairman of the Finance and Budget Committee.

He shall render at each annual meeting of this Society a full statement of all transactions of the Treasurer's office.

He shall notify the proper officer or committee chairman whenever ninety percent (90%) of the annual appropriation for any office or committee has been expended.

He shall collect and enter proper credits for per capita assessments received from component societies.

He shall perform such other duties as may be assigned by the House of Delegates or Board of Trustees.

He shall submit his accounts for audit at such times as the House of Delegates or the Board of Trustees may order.

Section 5—Board of Trustees

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board of Trustees shall organize by electing a chairman and a secretary. The chairman shall name the membership o all committees of the Board of Trustees. Meeting shall be called by the chairman, but any four (4 Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notice of meetings shall be mailed at least seven (7) day in advance of the meeting date. Nine (9) Trustee shall constitute a quorum.

(b) Executive Committee. The President, Presi dent-Elect, First and Second Vice-Presidents, an chairman of the Board of Trustees shall compos the Executive Committee. It shall act on emergenc measures when time does not permit a meeting o the Board of Trustees. Any action thus taken sha be subject to formal action of the Board of Trus tees at its next meeting.

(c) Powers. The Board of Trustees shall exercis general supervision over the affairs of this Society shall have authority to act between annual meet ings, and shall perform the following functions:

Make recommendations to the House of Delegates
Assign business to and advise in the deliberation of committees;
Supervise the work of the Publication Committee and appoint an editor and such other assistant as the publication of THE JOURNAL may require
Make suitable provision for the efficient conduc of the business of this Society;
Engage counsel as necessary and negotiate fees fo services to be rendered;
Determine all salaries;
Pass upon all recommendations for expenditures i excess of budgetary appropriations;
Bond the Treasurer, the chairman of the Financ and Budget Committee, and other necessary per sonnel;
Fill vacancies in all offices and elected committee until the next annual meeting, unless otherwis provided in the Constitution and Bylaws.

(d) Property. The Board of Trustees shall hav sole authority to lease, sell, or otherwise convey o dispose of any or all property of this Society, bot personal and real.

(e) Finance and Budget Committee. Three (3 Trustees shall serve on the Finance and Budge Committee, in accordance with the provisions o Chapter IX of these Bylaws.

(f) State Board of Medical Examiners. Actin for this Society, and in accordance with the statute of the State of New Jersey, as vacancies occur i the State Board of Medical Examiners, [by reaso of the expiration of term or otherwise] the Boar of Trustees shall nominate for each appointmen three (3) members of this Society. The names o such nominees shall then be transmitted to th Governor of the State of New Jersey.

(g) Annual Report. The Board of Trustees shal render annually to the House of Delegates a sum mary of its activities.

Section 6—Judicial Councilors

The Judicial Councilors shall be governed by th provisions set forth in Chapter VII of these By laws.

Section 7—Term of Office

All officers shall assume office at the close of the last session of the House of Delegates of the annual meeting at which they are elected.

Section 8—Resignation or Removal

Any officer of this Society may resign. He may be removed from office by action of the House of Delegates, if found guilty by that body of neglect of duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (⅔) vote of the delegates present and voting shall be required to effect such removal.

CHAPTER VII—JUDICIAL COUNCIL

Section 2—Councilors

The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of this Society. The Councilors shall elect their own chairman.

REFERENCE COMMITTEE NOTE: The only change recommended was the addition of the last sentence in Section 2 above. The remainder of Chapter VII—Judicial Council—is the same as printed in the present Constitution and By-Laws.

CHAPTER VIII—OTHER DELEGATES AND REPRESENTATIVES

Delegates and Alternate Delegates to other medical organizations shall be elected in accordance with the provisions of Chapter V of these Bylaws.

(a) American Medical Association. The terms of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December thirty-first thereafter.

In the absence of any Delegates, any Alternate Delegate shall be eligible to serve.

(b) Other Medical Organizations. When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such Delegates and Alternate Delegates shall be elected for terms of one (1) year.

(c) Representatives. Official representatives from this Society to other organizations shall be appointed by the Board of Trustees or by the President with the approval of the Board of Trustees. Their functions and terms shall not exceed those set forth in their official notice of appointment.

The revision was adopted section by section, chapter by chapter, and as a whole

The Reference Committee wishes to thank Dr. Louis F. Albright and his excellent committee for their untiring efforts in revising this portion of the By-Laws. This committee was at the meeting of the Reference Committee and aided considerably in the final report on the revision of the first eight chapters of the By-Laws.

I wish to thank the members of my committee for their excellent cooperation in this report.

Adopted as a whole

Special Actions by Delegates

At its first session (May 17, 1958) the Delegates voted to approve:

The Transactions of the 1957 House of Delegates, published as a supplement to the September, 1957, JOURNAL, and distributed to the membership—APPROVED

The following resolution was read by Dr. Fritts and unanimously adopted:

ALBERT BARKER KUMP, M.D.

Whereas, Almighty God in His omniscience has seen fit to summon from our midst Albert Barker Kump, M.D., 165th President of The Medical Society of New Jersey, and

Whereas, by his high character and exemplary life both as a man and as a physician, Doctor Kump has ever been a model and a genuine inspiration to all who knew him, and

Whereas, by his vision, initiative, and skill he has for long years and in many capacities rendered outstanding service to his profession and to his fellowmen, and

Whereas, As by his life we were all enriched so by his death we are all impoverished, therefore be it

Resolved, That The Medical Society of New Jersey, honoring him in death as in life, record its profound grief at his passing; and be it further

Resolved, That a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to his bereaved family.

Approved

Dr. Fritts then said: "It now becomes my proud duty to present the Fellow's Key which would have been given to Dr. Kump. The resolution has been properly inscribed. I give the resolution and the Key together in this leather-bound volume to Dr. Kump's widow and son."

SPECIAL SESSION

The House of Delegates at its second session on Sunday afternoon, May 18, 1958, took the following action: That the House of Delegates instruct the President of The Medical Society of New Jersey to call a special session immediately following the adjournment of the 1958 House of Delegates on May 19, 1958, to fill the vacancy which will then be created for the office of eleventh Trustee of The Medical Society of New Jersey.

In accordance with the above action, a special session of the House of Delegates was convened immediately following the adjournment of the 1958 House of Delegates on Monday afternoon, May 19, 1958.

Dr. Joseph R. Jehl, Clifton, was unanimously elected to fill the vacancy in the office of eleventh Trustee, created by the election of Dr. Ralph M. L. Buchanan as Second Vice-President. Dr. Jehl is elected for the unexpired term to end in May 1960.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION

(May 18, 1958)

Office	*Term*	*From*		*To*		*Nominee*
President-Elect	1 year	May	1958	May	1959	F. Clyde Bowers, Mendham
1st Vice-President	1 year	May	1958	May	1959	Jesse McCall, Newton
2nd Vice-President	1 year	May	1958	May	1959	Ralph M. L. Buchanan, Phillipsburg
Secretary	1 year	May	1958	May	1959	Marcus H. Greifinger, Newark
Treasurer	1 year	May	1958	May	1959	Rudolph C. Schretzmann, Bergenfield
Trustees:						
4th District	3 years	May	1958	May	1961	C. Byron Blaisdell, Asbury Park
5th District	3 years	May	1958	May	1961	Carl N. Ware, Shiloh
11th Trustee	3 years	May	1958	May	1961	Jerome G. Kaufman, Newark
Councilor:						
3rd District	3 years	May	1958	May	1961	Charles H. Calvin, Perth Amboy
A.M.A. Delegates	2 years	Jan.	1959	Dec.	1960	C. Byron Blaisdell, Asbury Park J. Wallace Hurff, Newark L. Samuel Sica, Trenton Elmer P. Weigel, Plainfield
A.M.A. Alternates	2 years	Jan.	1959	Dec.	1960	Ralph M. L. Buchanan, Phillipsburg Jesse McCall, Newton Herschel Pettit, Ocean City John H. Rowland, New Brunswick
	1½ years	May	1958	Dec.	1959	Samuel M. Diskan, Atlantic City
	(Unexpired term of Dr. Albert B. Kump, deceased)					
Delegates and Alternates to Other States:						
New York						
Delegate	1 year	1959 New York Convention				William F. Costello, Dover
Alternate	1 year	1959 New York Convention				Levi M. Walker, Atlantic City
Connecticut						
Delegate	1 year	1959 Connecticut Convention				Lloyd A. Hamilton, Lambertville
Alternate	1 year	1959 Connecticut Convention				S. Eugene Dalton, Atlantic City
Standing Committees:						
Finance and Budget	6 years	May	1958	May	1964	Anthony J. Conty, Union City
Publication	3 years	May	1958	May	1961	Joseph E. Mott, Paterson

Upon motions duly made, seconded, and carried, all nominees were elected to the designated offices and for the terms indicated.

DR. ALLMAN BECOMES A FELLOW

(May 19, 1958)

Dr. Gardner: "At this time, with the adoption of the new Constitution, under Article IV, Section 2 there is a provision which now reads: "Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society."

We are honored to have Dr. Allman as a member of our Society and his A.M.A. term will be completed within one month. So at this time I ask Dr. Henry B. Decker to bring Dr. Allman to the platform and present him with his Fellow's key from The Medical Society of New Jersey.

(The audience arose and applauded)

The President: I have a very special request to present a guest to you. Mrs. Malone is the Executive Secretary of the Jefferson Medical College Alumni Association. I'm going to ask Dr. Crowe if he will present her. (Applause)

Mrs. Malone: I'm glad to be here, and all of Jefferson, of course, is very proud of Dr. Allman and his achievements. I'm sure this means a great deal to him. I'm delighted to share in it. (Applause)

Dr. Decker: The institution of Fellowship in The Medical Society of New Jersey is an old institution and an honorable one. We are breaking the tradition of many years this year, which you will realize.

When we do this, I think we should have the Fellows introduced to the Society. Dr. George N. J. Sommer, Dr. Lancelot Ely, Dr. Spencer T. Snedecor, Dr. William G. Herrman, Dr. E. Zeh Hawkes, Dr. Ralph K. Hollinshed, Dr. J. Howard Hornberger, Dr. Aldrich C. Crowe, Dr. Harrold A. Murray, Dr. Elton W. Lance, Dr. Vincent P. Butler, Dr. Royal A. Schaaf, Dr. Lewis C. Fritts. (Applause)

This Fellowship is given for service, usually for long service. It is not given lightly, and because of this, it is a distinction and privilege; and with the Fellowship certain privileges and rights are given—the right to speak in the House of Delegates and the right to vote.

The background of this change starts with Dr. George Sommer who, when Dr. Allman became President-Elect of the American Medical Association, suggested that we should honor him at the completion of his presidency. He asked me to communicate with the Fellows to determine their opinion. They all acquiesced, with one exception who felt that such an honor was not great enough for Dr. Allman. So the amendment was introduced last year and it was carried into the present Constitution.

Dr. Allman has labored hard and long in service to his patients, to the medical profession in New Jersey and presently to the medical profession of the country. He has also served in other activities within New Jersey. His list of positions will cover four pages of single spaced typewritten sheets.

When the world was very young and coming out of chaos it was inhabited by Titans. One of these named Prometheus went down into a river valley and shaped out of the mud in the valley an image, an image which conformed to the image of the gods in Olympus. He breathed into the mass of mud and it lived and it was man. He went back to Olympus and brought fire down so that man, who has learned to walk upright, to look toward the stars and the heavens, had an agency that he could control, with which he could control his environment. He was censured by the gods for this, but he went back again and stole a portion of something that the gods treasured very highly. He returned to earth with it and he concealed it in the heart of man. For this the gods punished him terribly.

That substance that he stole is almost indefinable; it is hard to describe, but we all recognize it when we meet it. It is truth. We feel that in the hearts of physicians this substance, truth, is in greater quantity than in the average individual. But nowhere is it in greater quantity than in David Allman.

David Allman is a medical statesman. He is an individual who can see things as they are and know how things should be and can strive to produce the world as it should be. This is frequently difficult, but he has accomplished it as well, if not better than, any other individual that I know.

He is President of the American Medical Association. To achieve such an honor, preparations have to be made and there is usually a forerunner. You must recall that in all the history of The Medical Society of New Jersey no other member has been President of the American Medical Association. Of course, the American Medical Association is much younger than our State Society. However, in a hundred years of existence no other member

of this Society has been A.M.A. President, and we have had many distinguished physicians in New Jersey. Read the list of Fellows who have departed and Fellows present. They are not without distinction.

Now, we had a similar man who was a Fellow of this Society, a man similar to Dr. Allman, who had the same characteristics. He was a delegate to the American Medical Association and there his obvious honesty, his integrity shone forth so that he was immediately trusted by the delegates of the American Medical Association as we trusted him. Unfortunately, he died, but he prepared the way for Dr. Allman, so that when Dr. Allman moved on to the scene the path was smooth and the stones taken out of it.

Dr. Allman has had many honors. They are all reflected on us because we are part of Dr. Allman and he is part of us. I feel that he is one of the most worthy individuals for Fellowship in this Medical Society that we have ever produced.

Now, it is the custom for the junior Fellow to present the key of Fellowship to Dr. Allman. I'm going to ask that Dr. Hornberger, who is the senior Fellow present, come to the platform with Dr. Fritts, who is the junior Fellow.

This is the key of Fellowship and as it passes from your hand to Dr. Fritts, it passes through all the hands of the Fellows, both here and not here. (Applause)

Dr. Allman: Fellows, Delegates, Friends: The receipt of such a distinguished honor demands a long acknowledgment. I know how hungry and tired you must be after the arduous morning you have had, and I'll try to make my remarks brief; but, believe me, they are with my deepest feelings.

You all know the distinguished group of men I am joining. You know the terrific precedent that has been broken by electing one who has not been President of this Medical Society as a Fellow, and I assure you that I am deeply appreciative of the honor and the thought that started this and the work necessary to culminate it.

I have received many honors this year. I have had an honorary degree of Doctor of Human Letters conferred upon me. My own alma mater, represented here today by Miss Malone, conferred upon me an honorary LL.D. degree last June. On the 12th of June, Temple University in Philadelphia will confer upon me a Doctor of Science degree.

I value them all highly. They are all wonderful. They come from people who have met me and know me to some degree and probably have liked me to some degree. But this key comes from you gentlemen with whom I've worked and lived for many years. You really know me, or at least you should really know me and to have such an honor conferred upon me by the men who know you best, to me is the deepest source of satisfaction.

Eulogy of Albert Barker Kump, M.D.

by

DAVID B. ALLMAN, M.D.

HAIL AND FAREWELL!

Mr. President; officers and members of the Board; members of the House of Delegates; and friends:

Just one short year ago, it was my happy privilege, in behalf of this House of Delegates and of all the members of The Medical Society of New Jersey, to cry "Hail!" to Albert Barker Kump upon the occasion of his accession to the presidency of this Society.

Today it is my melancholy task, in the name of all of us, now to say to him, "Farewell!"—as in a spirit of genuine grief we bow to the will and wisdom of God.

Nothing is harder to bear in life than the loss of one we love. Nothing is harder to fill than the aching vacancy that such loss leaves in our hearts. Still, appreciating all the benefits and joys which have been ours because of Albert Kump, today each of us, I am sure, is moved to say with the poet

"I hold it true, whate'er befall;
I feel it when I sorrow most;
'Tis better to have loved and lost
Than never to have loved at all."

The secret of the greatness of any truly great man lies always in the fact that in his life he finds something to serve which he regards as more important than himself. In such service, a man transcends the narrow limits of the world of self, and, laboring unselfishly, achieves a stature and a magnificence impossible for those who are less generous, less expansive of soul.

Albert Barker Kump early found his inspiration and his life-long dedication. That which he found more important than himself was the welfare of his fellowmen. Because of that fact, not only we who knew him intimately, but all his fellowmen are the richer for his having lived. Because of that fact, though we mourn our loss, we are forever grateful for the privilege of having known him.

It must not be assumed that because of his all-embracing devotion to his fellowmen, Albert Kump was any the less ardent in his personal affections and attachments. He was a devoted and loving husband and father, an affectionate son and brother, a constant and loyal friend.

There was also about him an immutable, forthright boyishness, at times saved only from impishness by his innate breeding and his abiding sense of dignity and propriety. His best satisfactions always involved the satisfactions of others. He most enjoyed those goods of life which he most shared with others.

Here was a man with the frank eagerness of a boy, with a sense of justice and of right worthy of a Solon, with an aggressiveness for truth worthy of a warrior, with a constancy as dependable as true love, with a chivalrous honor worthy of a knight. Here was a man!... in all the connotations of compliment which that term at best can signify. We were fortunate in the privilege of association with him. He shall remain with us, as an exemplar and an inspiration, until all memory fades.

From the depth of our own distress we can begin to know how abysmal must be the sense of loss, how fathomless the sense of deprivation that must harry the hearts of those who loved him with the intimacy and fervor which characterizes family affections at their best. To his widow, his son, and all his sorrowing family, we therefore extend our deep condolences.

Could he advise us, I am sure Albert Kump would ask us not to indulge ourselves in languishing grief. He gave no quarter and paid no deference to the disease which brought him low. Likewise, I am sure, he would not truckle —nor have us do so—to death.

Let us not linger in contemplation of our loss in his death, but concentrate rather on the benefits which were ours from his life. Let us from his life catch the spirit of his dedication. Let us from his character derive a pattern for our own living which will lead us, as it led him, to enrich the world. Let us follow his leadership now as in the days of his presence in our midst; and thus let us keep him essentially with us, for our own good and the general good, through all the days that yet remain for all of us to live.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI July, 1958 No. 7

The Chest Roentgenogram and Chest Roentgenographic Surveys Related to X-Ray Radiation Effects and Protection from Radiation Exposure

Executive Committee of the American Trudeau Society, American Review of Tuberculosis and Pulmonary Diseases, February, 1958.

The chest x-ray continues to be an important part of all tuberculosis case-finding programs and an important and dependable tool in early diagnosis of unsuspected chest disease.

In June of 1956 the National Academy of Sciences, National Research Council, called attention to the "Biological Effects of Atomic Radiation," especially as it affects the human body and its reproductive organs. Later reports discussed the possibilities of effects of body radiation upon the blood system, with leukemia as a delayed effect.

This discussion on radiation effects has led everyone—scientists, physicians, and laymen—to think deeply concerning them and to weigh the benefits from x-ray diagnostic procedures against the liability of harmful effects of radiation. Most of the factual information on this aspect of low doses of ionizing radiation has come from animal experimentation.

In people who are ill, the needs for radiological studies are great and the diagnostic benefits outweigh the possible hazardous effects of radiation. All radiation exposure that serves no useful purpose should be scrupulously avoided.

It is well recognized that no standard pattern of radiation exposure is delivered by any standard type of x-ray machine. Each x-ray unit must be provided with all necessary safety devices for minimizing gonadal and general body radiation. This must be done by persons trained in radiological protection.

Who Should Get X-rays?

The American Trudeau Society has emphasized that chest roentgenograms are only justified if they lead to the detection of previously unsuspected or clinically significant, curable lung disease, followed with appropriate therapy. If abnormal chests are not followed up, radiation has been wasted.

Therefore, it is essential for those engaged in the detection of pulmonary disease to evaluate their yields. Among certain population segments in which there are high yields, periodic chest x-rays are the most practical approach. Among infants, children, young adults, prenatal patients, and especially young diabetics, the tuberculin test should be used as the preliminary screening technique whenever possible, and the tuberculin reactors should have x-ray examinations of the lungs. However, aside from screening, every child should have a single x-ray film for the identification of congenital or developmental defects and nontuberculous disease, and for comparison with any films taken later in life. Only those x-ray units that meet modern requirements for radiation protection should be used.

What Type of Apparatus Should be Used?

Other factors being equal, the amount of radiation necessary for a satisfactory chest film is least with a standard 14 x 17 film in a cassette with intensifying screens. In comparison, there is approximately 3 to 5 times more radiation using the mirror optics photofluoroscopic unit and about 10 to 20 times the radiation exposure when using the standard lens camera photofluorographic machine. This is still a very small amount of radiation, but these figures may be multiplied by 100 if the apparatus is not properly equipped with protective devices.

Where the number of survey films taken is small or when modern protective devices have not been installed, it is better to use standard 14 x 17 films, even at a higher cost. Where the

number of films taken per day is large, or the machine must be moved frequently, a properly equipped photofluorographic unit is the most practical apparatus. The increased amount of radiation involved is small and is warranted where the yield of new cases is significant.

Whenever a new photofluorographic unit is purchased the newer mirror optical system camera is to be preferred over the ordinary lens system even at greater cost. Screening of groups by fluoroscopy should be discouraged because the results are not accurate enough for diagnostic purposes; there is no permanent film record of the examination; and the radiation exposure involved is excessive.

The Nature of Radiation Effects

Populations are being exposed to a variety of radiations from natural and artificial backgrounds as well as from medical examinations. Exposure received by the population today from all sources appears to be at a lower level than that which has produced harmful effects in humans and experimental animals.

Those responsible for screening programs should ensure that the radiation dose is maintained at the lowest practicable level both to those being examined and to equipment operators.

Conclusions. The kernel of the problem of radiation effects is the awareness by the public, physicians, and tuberculosis workers that the whole subject is one of weighing the benefits of radiography against the known and the unknown effects of radiation exposure. It should remain clear that radiation that serves a useful and necessary purpose is warranted, but it should be used with the best protective devices. Putting the chest x-ray examination in its proper perspective, the radiation exposure to the gonads or body from a single chest film, using a well monitored machine, is infinitesimal when compared to the commonly used x-ray diagnostic procedures directly involving the gonadal areas.

Recommendations. Several specific recommendations from this report can be made to the constituent associations of the National Tuberculosis Association and American and State Trudeau Societies.

1. Chest x-ray surveys must be continued in the field of tuberculosis, in the detection of cancer, industrial thoracic disease, acute and chronic nontuberculosis infections, chest tumors, and cardiovascular abnormalities.

2. Conventional and photofluorographic x-ray units with adequate protective devices may be used to survey segments of the population which are expected to show a high yield of thoracic disease.

a. The installment of certain protective devices should be made *now.* These include proper cones, proper filtering, shielding devices for subject and operator, and exposure controls of an automatic nature.

3. Tuberculin testing in infants, children, young adults, prenatals and young diabetics should be developed as a primary guide to tuberculosis contacts and as one case-finding method, limiting x-ray of the chest to those with a positive tuberculin test.

4. Case-finding programs should be reassessed to determine those segments of the population most deserving of chest x-ray surveys or tuberculin testing.

5. The instruction and training of personnel should include information concerning the protective devices for all types of x-ray units.

6. It should be made known to health workers and the public that effective steps have been taken to minimize radiation exposure involved in taking chest x-rays. The need for early diagnosis and treatment of all forms of pulmonary disease should be emphasized.

7. Members of the American Trudeau Society and constituent associations of the National Tuberculosis Association might well promote the training of personnel skilled in radiation protection. The leadership of these organizations in the field of thoracic disease would help to assure the public that radiation exposure was at a minimum and that protection was maximum wherever chest x-ray examinations are conducted under their sponsorship.

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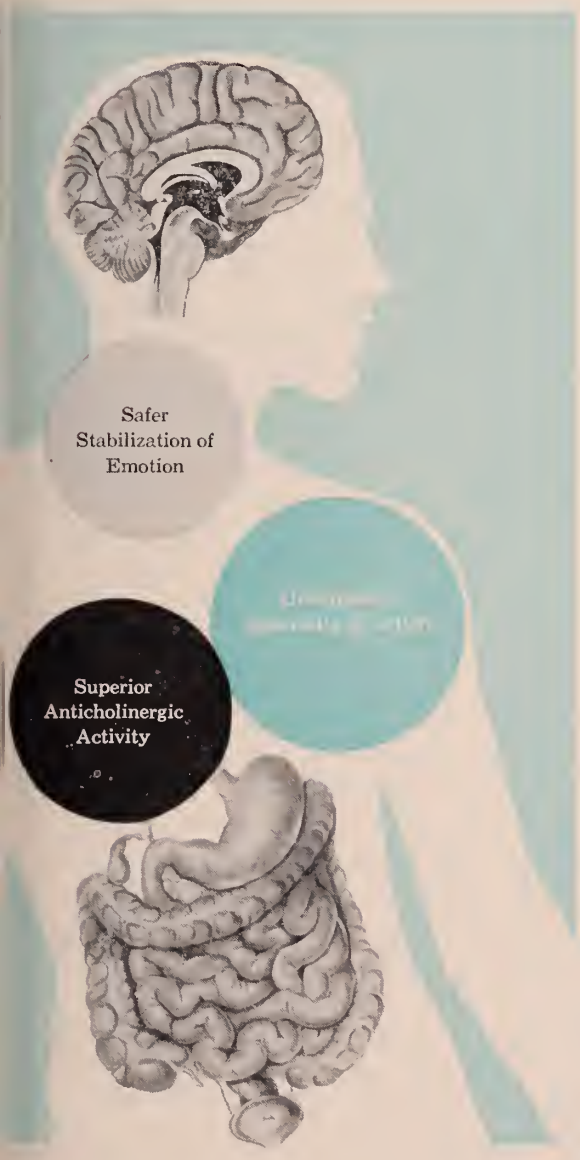
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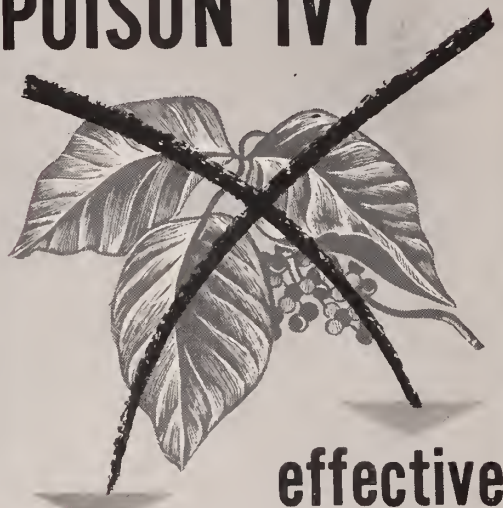
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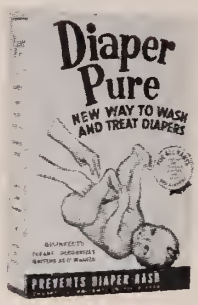
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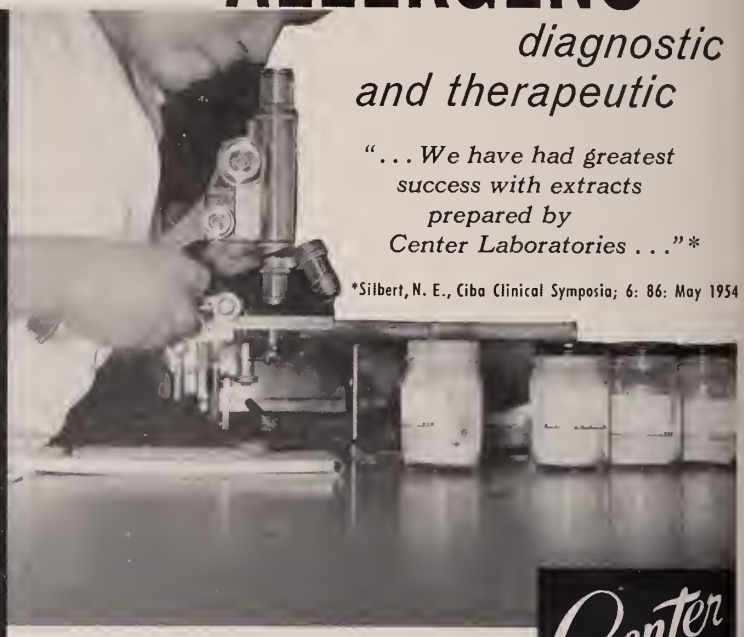
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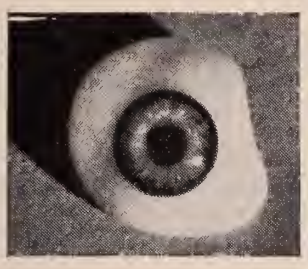
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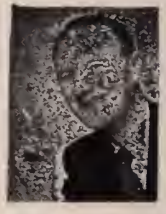
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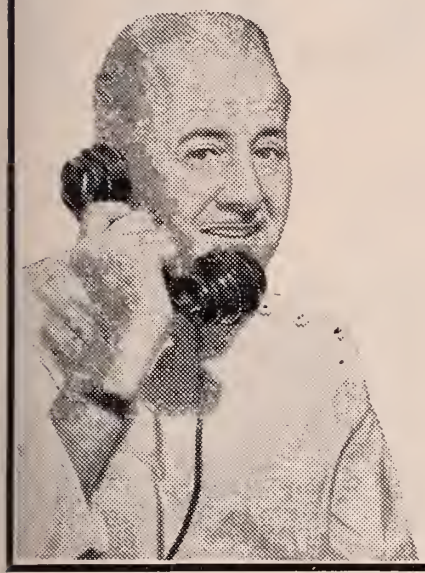
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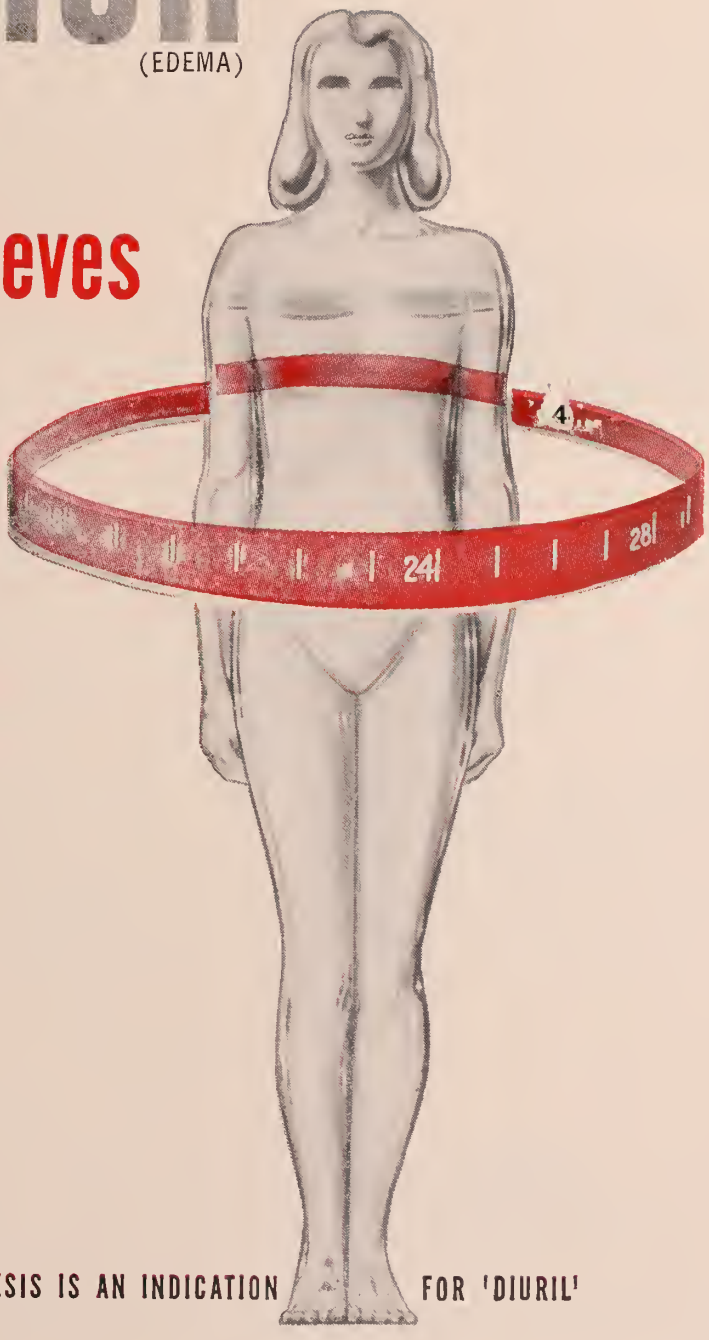
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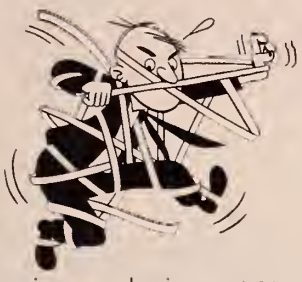
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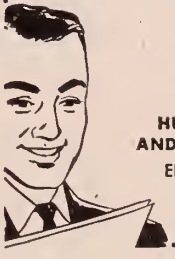
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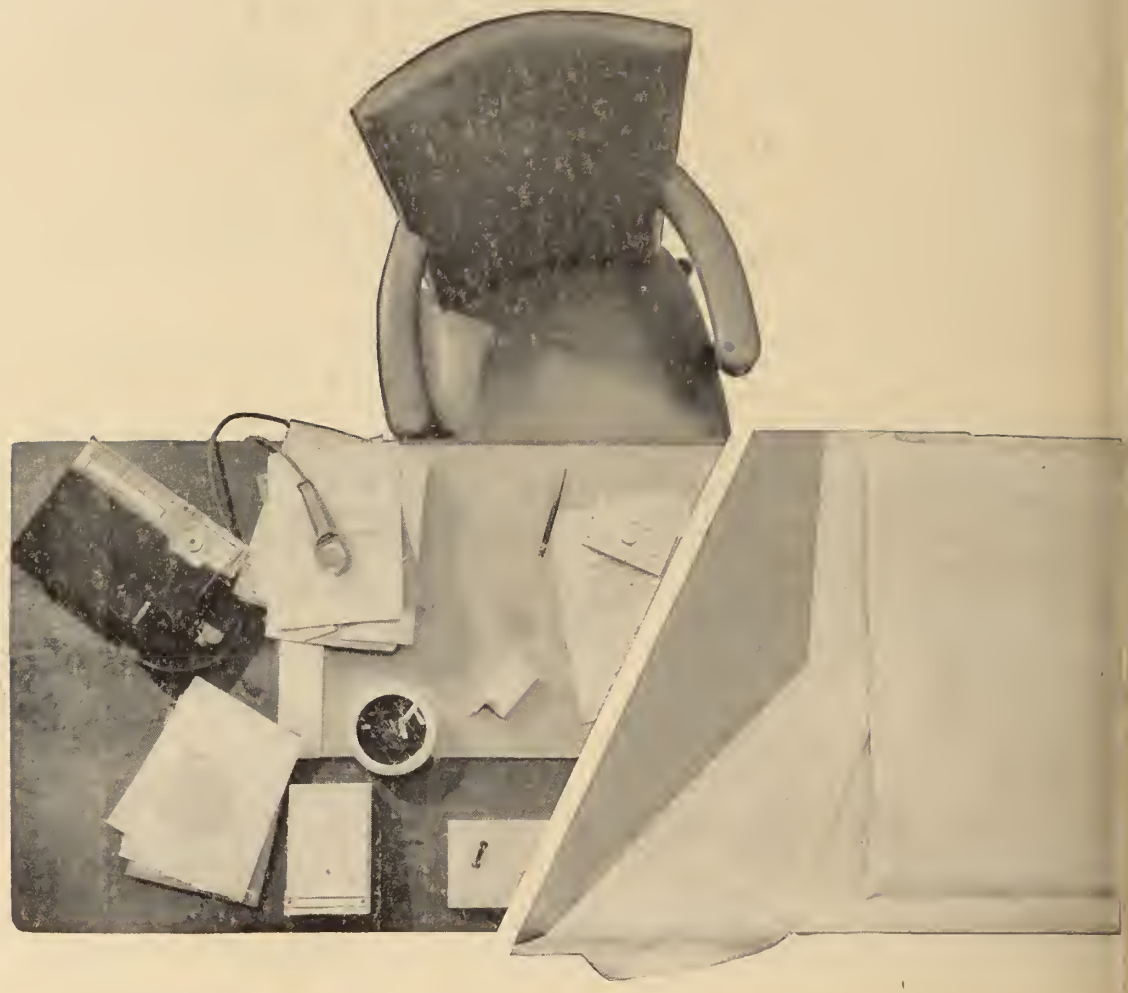
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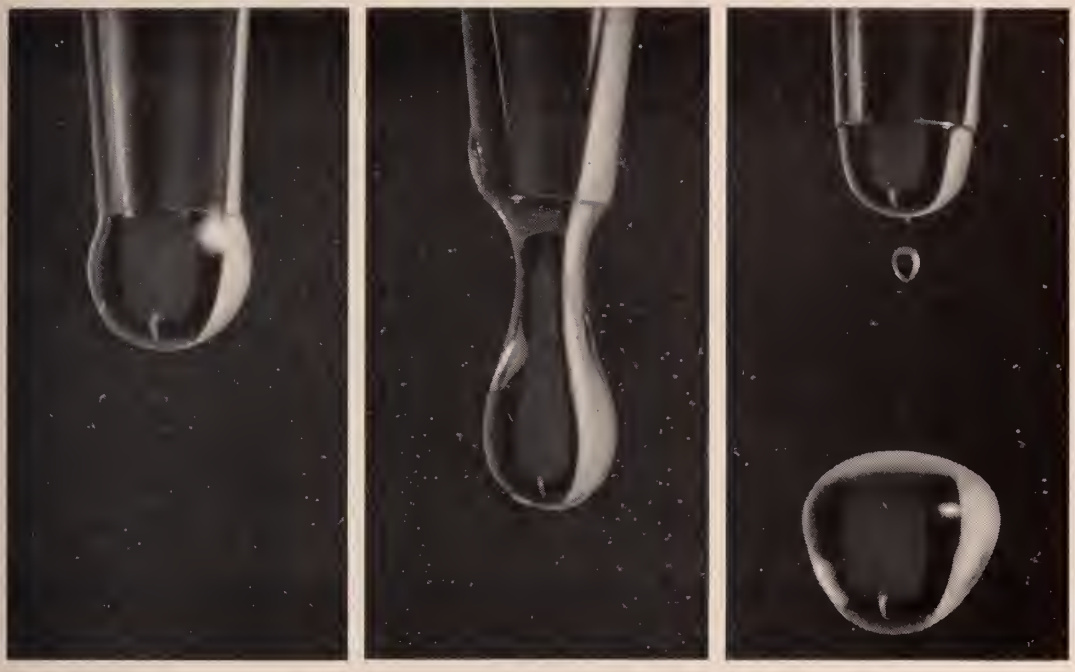
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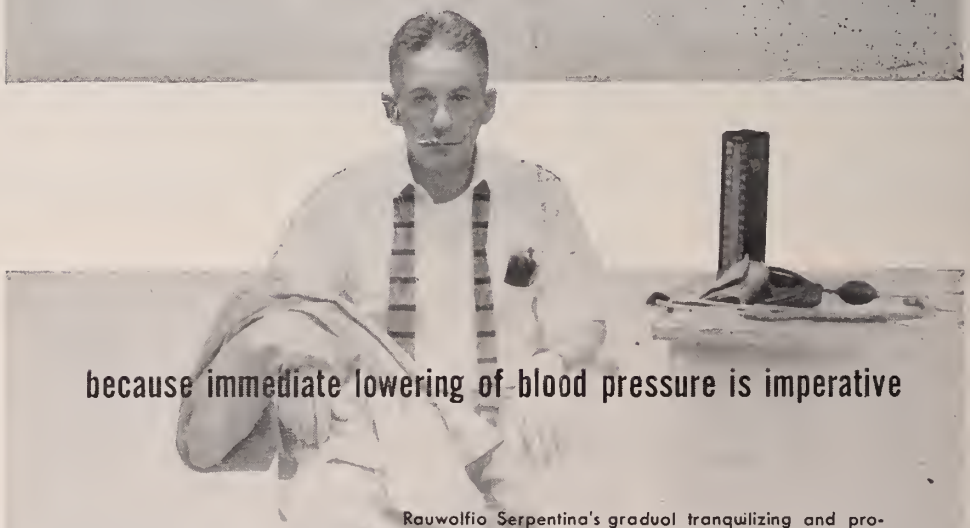
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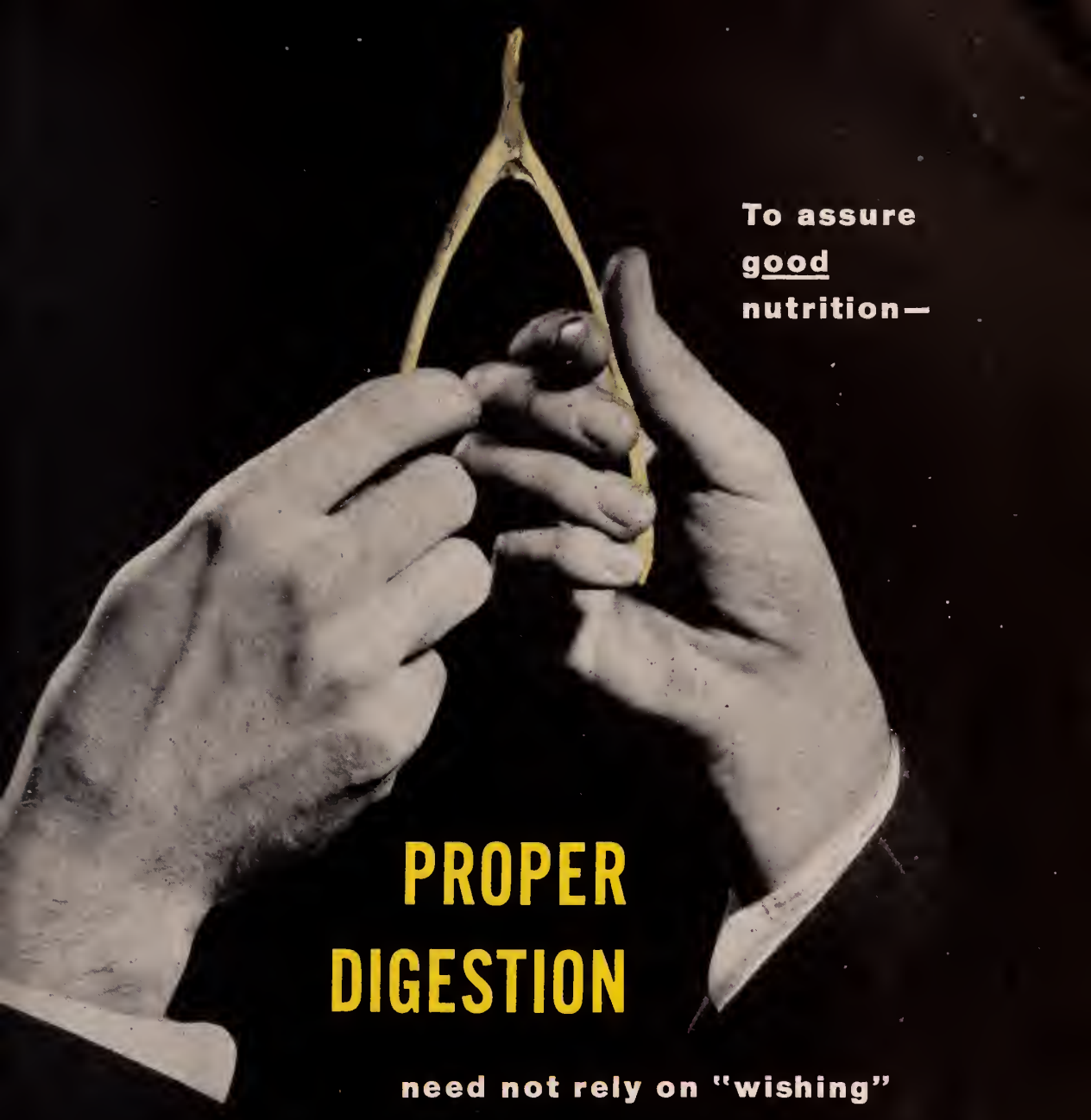
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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.



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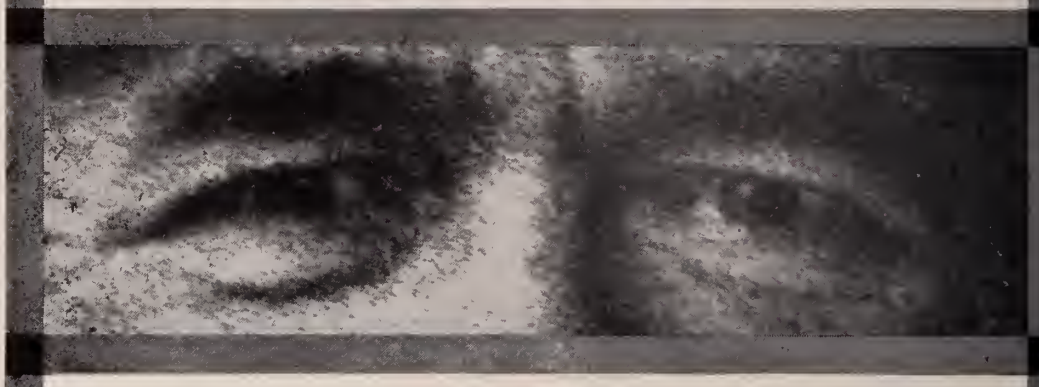
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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: A Clinical Evaluation of Ectylurea (NOSTYN®), in press.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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References:

Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

Editorial: *New England J. Med.* 258:48-49, 1958.

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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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STUDY 1[1]		"marked"	maderote	slight	none
Skeletal muscle spasm secandary to ocute traumo	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentaus strains	8	4	4	—	—
Torticallis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusians, fractures, and muscle sareness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibramyasitis	8	8	—	—	—
Torticallis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disarders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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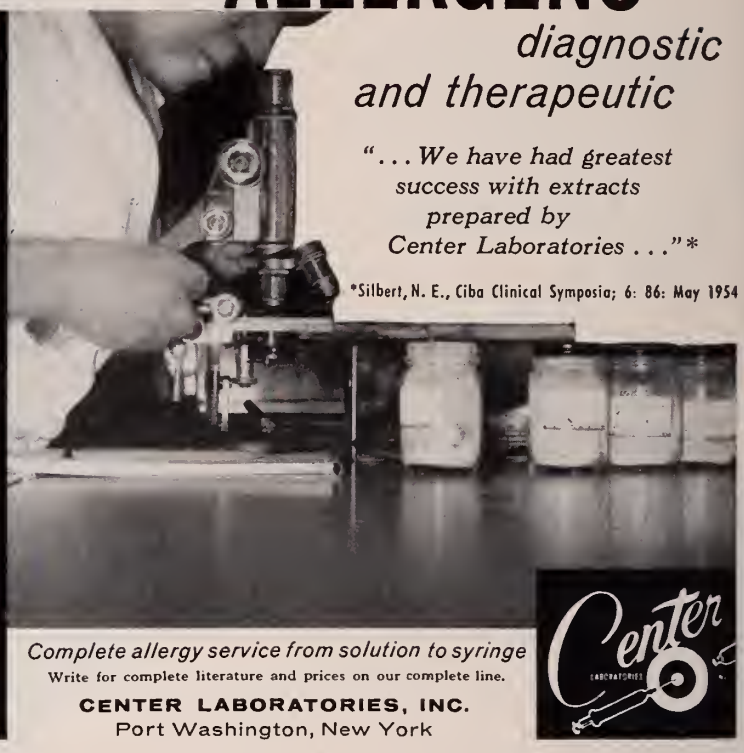
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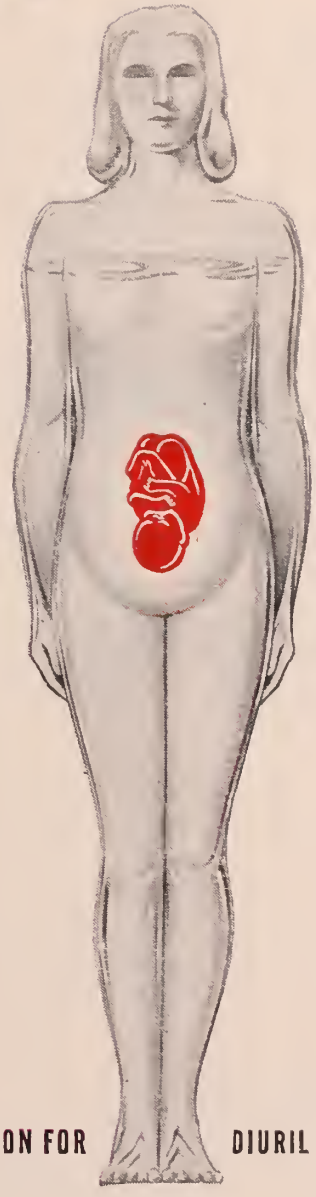
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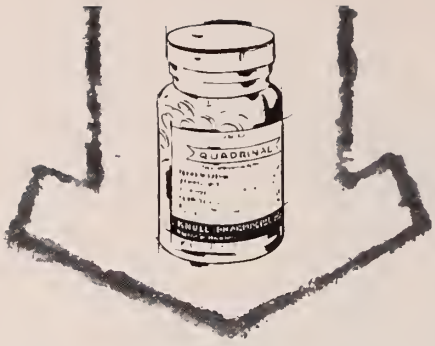
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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:504, *Dec. 1957.*

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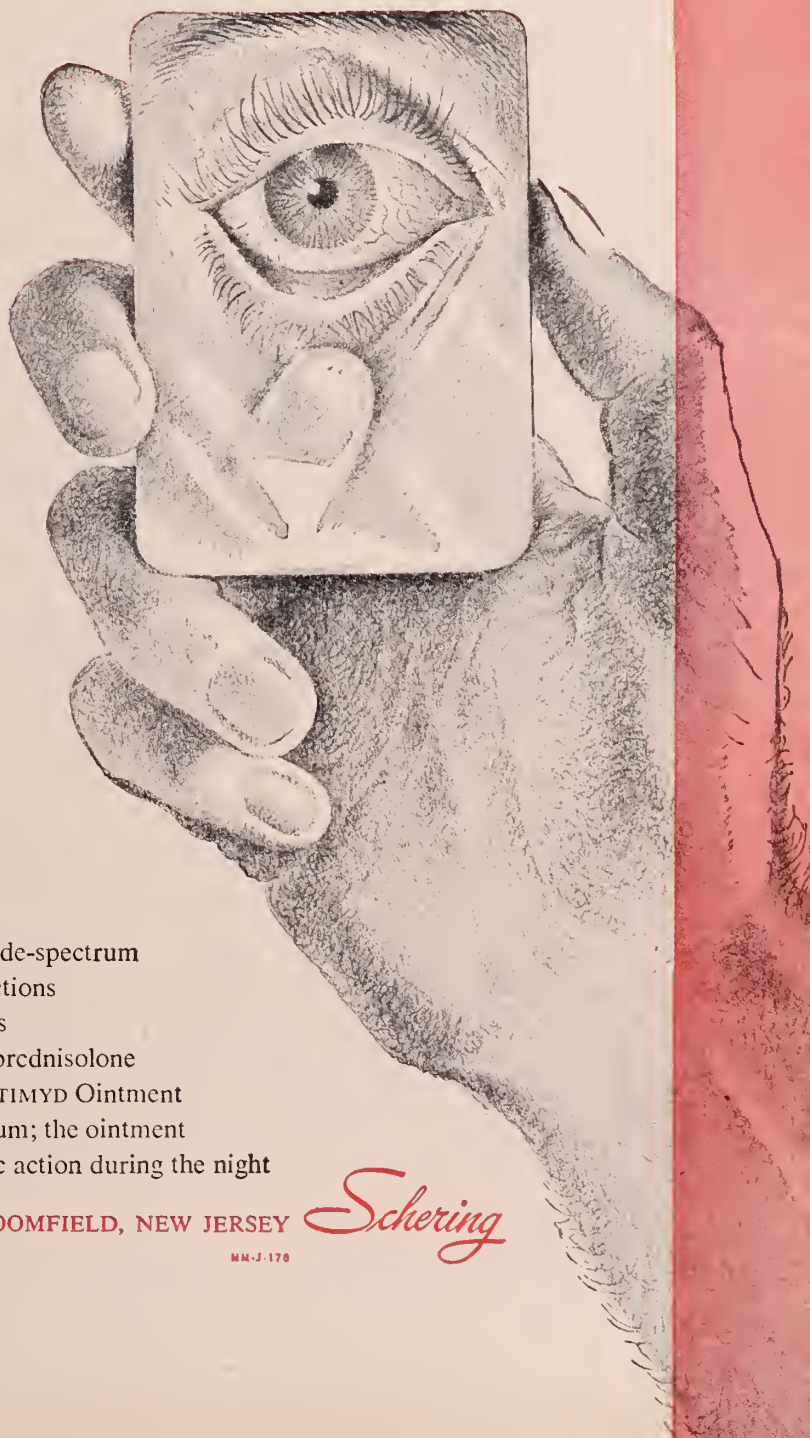
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Editorials • • •

Mike and Ike Can Look Alike

It seems that Ike and Mike were patients in the same semiprivate room. Ike needed a blood transfusion. When the technician arrived both patients were indulging in an after-lunch siesta. The usual bed cards were there, but one bed was elevated, obscuring the card; and the other card was concealed by a carelessly placed blanket. At the first bed, the technician stopped, asked Mike if his name was Ike. Mike grunted and she took the blood and typed Mike. It was a wonderfully accurate typing—Rh factor and all. Only it wasn't Ike's type or Rh. The nurse passed by, asked the technician why she was needling Mike, and thus prevented a tragic error. This story is related by Whitelaw Hunt, then Administrator of the Cooper Hospital in Camden.[1]

A transfusion is a particularly fertile area for patient misidentification. This procedure is often conducted in haste, under pressure, by persons who do not know the patients, on people who are confused, comatose or delirious. In fact, Discombe[2] tells us that "incompatible transfusions are due more often to gross blunders in identification than to obscure antibodies."

Nowadays the problem of patient identification applies chiefly to adults. Baby identification is pretty well assured by methods adopted by all good hospitals. Even here the system is not foolproof. A recent editorial in the *Journal of the American Medical Association*[3] for instance, calculates that in one state, eight baby mix-ups were reported in an 18-month period. There should be no such confusion at all if hospitals followed the AHA procedure—which includes footprints, handprints, wrist bands, ankle bands, showing the baby to the mother at each feeding, having the mother identify and acknowledge the baby each time. Any baby mix-up is poignant, for it may mean that the parents are haunted by a life-time of doubt.

But adult mix-ups can be more immediately

1. Hunt, Whitelaw, H.: Modern Hospital, July 1950.
2. Discombe, M.: Lancet, 1:734, March 1952.
3. Issue of September 22, 1956.

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tragic. There are verified reports of amputating a foot from the wrong patient,[4] letting the family bury the wrong body[5] or removing the gall bladder from a patient hospitalized for hand injury.[4] Probably every large hospital can report (if they would) some embarrassing anecdotes of misidentification.

We can't visualize this as happening to any of our adult patients. "After all," we say, "if I send a patient in for a heart attack, he just won't let them take out his appendix." But, a hospital is, among other things, a hotel for the comatose, collapsed and confused. The high turnover among nurses, interns, and attendants means that the people coming into a ward or private room often have no personal knowledge of the patient. Technicians appear suddenly from laboratories tucked away in the corner—and vanish again into those same laboratories, having only a brief needle-prick contact with the patient. Anesthesiologists and anesthetists float into the patient's consciousness from nowhere and are soon obscured in clouds of dreamless sleep.

Patients have names, but names are not unique. Every large hospital must have on its patient rolls today numerous Smiths, Millers and Johnsons. Even the oddest of names has its duplicates—look at the phone directory for instance. First names are even less distinctive. And there are only a limited number of procedures done in the average hospital. So it is not too much of a strain on the imagination to suppose that two patients both named Angelo, Bennet, Cohen or Dombrieweski, need transfusions on the same day. They will certainly both be getting blood counts, x-rays, or enemas. An identification system must be rugged enough to prevent confusion between two patients of the same surname getting the same procedure on the same day.

Cardboard tags on beds are unreliable. They are too easily torn off, obscured, detached or misread. Other methods are bands, tapes, dog tags, lettered beads, and photographs. Wrist and ankle bands may be made of silk, wool, metal, ceramic, plastic or adhesive tape. Whatever the method, there is incumbent on all hospitals the development of a fool-proof system of identification. Many humerous stories are told about errors—and maybe it doesn't hurt to get an enema ordered for another patient, or to have an unnecessary blood typing. But when it happens to *your* patient, the mistake can be gruesome, embarrassing or tragic.

It is never funny.

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As a spokesman for the World Medical Association, the "international voice of organized medicine" representing 750,000 physicians in 53 nations of the "free world," said recently: "American physicians are singularly fortunate in having met their social and economic problems by voluntary action, turning back the threat of political domination."

This is good to hear, but it must be remembered that while physicians have *met* their social and economic problems, they are still a long way from *solving* them. Through their own Blue Shield program (and with the help of the many commercial insurance companies that have followed the trails blazed by Blue Shield) physicians have made a substantial be-

4. Modern Hospital, February 1953.
5. Australian Hospital Magazine, June 1952.

ginning toward providing basic medical care security for all of their patients. Still to be solved are difficult problems in the care of long term and chronic illness, the aged and rural populations.

Blue Shield offers us a unique instrument with which to tackle these problems. Whether it will suffice to save America from compulsory solutions will depend on the vision and energy and public spirit which every doctor brings to the support and guidance of his own Blue Shield Plan.

Coffee Break

Theobroma—literally "food for the gods" —was what they called the cocoa beverages. The cheering and comfort here were matched by the pleasures of the Kola nut or, in the modern world, the refreshment of cola drinks. In South America, the drink was maté, in England it was tea, in the United States it was coffee.

Maté, kola, theobromine, coffee, tea, cola, and cocoa—through them all runs the thread: caffeine. That is what they have in common—that amazing methylated xanthine, also known as theine.

Here in the words of William Cowper are "the cups that cheer but do not inebriate." Tea and Coffe, maté and kola have given comfort and solace to half the world. "Tea," said Colley Cibber, "thou safe, thou sober, sage and venerable liquid."

Coffee houses and tea houses have been philosophers' corners for centuries. Out of them have come intrigue, gossip, insurance, and the distribution of the news of the day. In the U. S. A. one billion pounds (not a million nor ten million, not a hundred million, but a well-rounded unimaginable billion pounds) of coffee are consumed annually. Caffeine stimulates the cortex, so that the office coffee break leads to more production per day, not less. Indeed, England started on its conquest of a world-wide empire only after it became a tea drinking nation.

It is not only a cheering stimulant but a safe one. Not a single human fatality has ever been reported from coffee. It makes no one drunk, robs no one of his dignity, lulls no one into Nirvana. It stimulates the myocardium, increases coronary blood flow, dilates peripheral vessels, keeps the kidneys busy, augments gastric secretion, increases the metabolic rate and serves as an antidote to poisoning by depressants.

It is the great American institution that knows no class lines. Truck drivers and debutantes, professors and stenographers, the unemployed in a bread line, the opulent in a banquet hall turn to coffee. It is a friend who never betrays, as does alcohol. It is a pleasant addiction that does not enchain as do the opiates. It is a social lubricant, a versatile medicine, an aid to clear thinking.

Here's to the coffee hour! Indeed, in some progressive offices the coffee periods are now being punctuated by work breaks. To one who is dedicated to work, a midmorning coffee or a midafternoon tea is a means of facilitating production. To one who is bored by his work, the coffee break is the best time of the day. *Theos broma,* indeed, food for the gods!

Adrian M. Sabety, M.D.
East Orange

Harvey M. Ewing, M.D.
Montclair

Mitral Commissurotomy*

Fifty Consecutive Cases with No Operative Mortaliy

In this hopeful article, the authors suggest that if the practitioner does not consider cardiac surgery for patients with rheumatic heart disease, he may be remiss in his duty. The performance of 50 consecutive mitral commissurotomies without a single operative death is the commendable record here detailed.

Recent progress in the surgical treatment of stenosis of the mitral valve has been impressive. Sporadic attempts to alleviate mitral stenosis were made earlier in this century, with surgical correction attempted in a few isolated cases. In 1923, Cutler [1] and Levine reported their first efforts at mitral commissurotomy. Over the ensuing years, Graham, Souttar [2] and Allen operated on ten patients with mitral stenosis. Only two survived and only one improved. This single case certainly did not justify the prohibitive mortality, so that further clinical trial was abandoned. Recently, under the inspiring leadership of Bailey,[3] Harkens [4] and Brock, the surgical relief of mitral stenosis has become feasible and is now accompanied by an acceptable mortality and morbidity, as is demonstrated by this report.

The present day success of the surgical procedure is due primarily to a better understanding of the abnormal physiology of mitral valvular stenosis and its alteration toward normal by surgery; and, to the tremendous strides which have been made in operative technic, anesthesia, pre- and post-operative case care, and, in the selection of patients for surgery.

It is under these improved conditions that we are able to report our experience in fifty consecutive cases of mitral commissurotomy with no operative mortality.

Earlier attempts at surgical correction of mitral stenosis were made by introducing a valvulotome into the heart, with the removal of a segment of the valve ring. This procedure usually met with catastrophic results, ending with severe and often fatal degree of mitral insufficiency.

Successful surgical correction of mitral stenosis, with marked reduction in operative

*From the Heart Unit, the Hospital Center at Orange, N. J.

1. Cutler, E. C., Levine, S. A. and Beck, C. S.: Surgical Treatment of Mitral Stenosis. Archives of Surgery, 9:689 (1924).

2. Souttar, P. M.: The Surgical Treatment of Mitral Stenosis. British M. J., 2:603 (1925).

3. Bailey, C. P., Glover, R. P. and O'Neill, T. S. E.: The Surgery of Mitral Stenosis. Journal of Thoracic Surg., 19:16 (1950).

4. Harkens, D. E., Dexter, L. B., Ware, P. F. and Norman, L. R.: The Surgical Treatment of Mitral Stenosis. New England J. Med., 239:801 (1948).

mortality, came about with the introduction by Bailey and Harkens[4] of the important concept that the mitral stenosis could be relieved and serious regurgitation (insufficiency) avoided by the careful separation of the fused commissure of the valve with a knife or finger. Better understanding of the mechanism of valve action brought forward the technic of valvulotomy by incision at the point of fusion of the leaflets, thus preserving the integrity of the leaflets and restoring valvular action. A corollary to this has been the added procedure of separating any fused chordae tendinae in order further to improve valve function.

The practitioner who treats patients with rheumatic disease of the heart assumes a real responsibility for any complications which may arise if he fails to advise a patient with mitral stenosis to have corrective surgery when such a procedure is indicated by accepted methods of diagnosis and evaluation. It is of extreme importance that all general practitioners and internists familiarize themselves with the clinical picture to be able to guide their patients to the proper treatment before irreversible damage is done.

The clinical manifestations of mitral stenosis vary with the degree of narrowing of the mitral orifice and with the amount of complicating pulmonary vascular resistance. Early in the course of the disease physical signs may be meagre. If the heart rate is relatively slow the diastolic murmur at the mitral area may easily be missed. It can be brought out by increasing the heart rate and by listening to the apical area with the patient lying on the left side. The opening snap of the mitral valve adds further evidence of the lesion. If atrial fibrillation is present the crescendo presystolic murmur at the apex may not be heard.

With increasing stenosis and resultant increase in pulmonary vascular pressure, dyspnea becomes the leading symptom. As the disease progresses the pulmonary hypertension becomes worse and bouts of pulmonary edema and recurrent hemoptysis become more common. This unfavorable progression of the disease may be due to a low grade chronic activity of the rheumatic disease or repeated episodes of acute rheumatic fever. Increasing stenosis of the valve with rising intrapulmonary blood pressure will eventually result in right heart failure. Atrial fibrillation commonly occurs in the natural history of the disease and further impairs the functional capacity of the heart. This arrhythmia carries with it the added threat of embolism.

THE DIAGNOSTIC WORK-UP

To do justice to a patient with rheumatic heart disease, especially where a mitral stenosis that may require surgery is suspected, it is important that certain basic diagnostic and evaluation procedures be carried out. A careful history is essential, not only to elicit a rheumatic history but also to establish the extent and the duration of symptomatology and the presence of atrial fibrillation and symptoms suggesting embolic phenomena.

The physical examination is of major importance in determining the existence of mitral stenosis and its degree, as well as the presence or absence of mitral regurgitation. When a systolic murmur is heard at the mitral area you can suspect regurgitation but you cannot determine the degree of regurgitation by physical signs alone. Evidence of pulmonary congestion and signs of right heart failure are important.

After the two basic steps of history and careful physical examination, other procedures are necessary:

1. *Laboratory*: Besides routine tests, sedimentation rate, C-reactive protein, antistreptolysin titre and a record of the temperature are essential to determine possible rheumatic activity.

2. *Electrocardiograms*: Are helpful in demonstrating cardiac rhythm, as well as possible overloading and strain of the various cardiac chambers. It is important to know whether there is any right heart strain, or any conduction abnormalities or P wave changes.

3. *X-rays*: It is essential that the patients with presumed diagnosis of mitral stenosis have proper radiographic study, including both fluoroscopy and chest x-rays. If the disease is present to a significant degree, "mitralization" of the cardiac contour is seen, characterized by left atrial and right ventricular enlargement, and dilatation of the pulmonary artery. Characteristic straightening or convexity of the left heart border is also noticed. Unless other valvular lesions are also present, the left ventricle usually is not enlarged. The left

atrium, in relatively "pure" mitral stenosis, presents itself as a chamber of moderate diameter, seen indenting the barium filled esophagus in the RAO fluoroscopy position over a relatively short distance. This is in contrast to the rather tremendous saclike dilatation of this chamber so often seen in significant mitral insufficiency, where the paradoxical posterior pulsation of the atrium synchronous with ventricular systole is noted. A search for calcification of the mitral valve is important for its presence has a direct and undesirable bearing on the prognosis of the surgical result. It may be seen with careful, well accomodated fluoroscopy; it is not found, however, on the usual routine chest films, even though they be perfectly satisfactory for studying the lungs and cardiac silhouette. For proper roentgen study of the valve, the intensity and exposure time of the films should be such that the motion of the valve will not cause blurring. In the posteroanterior and lateral films of the chest, differentiation of calcification in the mitral and aortic valves can be made by their comparative location.

4. *Cardiac catheterization*: If there is any real doubt as to the extent or "purity" of the mitral stenosis, or even of its presence, right heart catheterization or the more recent left variety, or both should be done further to determine the advisability of surgical attack.

The patients in our series were selected for mitral commissurotomy only if evidence of symptomatic mitral stenosis in a relatively pure form was present. A moderate degree of mitral insufficiency, however, did not preclude operation. Right and left heart catheterization, as well as direct pressure recording at the time of operation, were done when such studies seemed indicated.

PROCEDURE

PROPERLY to select patients for surgery and to evaluate the severity of mitral stenosis, the procedure at the Hospital Center in Orange has been to present the patient who is a potential candidate for surgery to the weekly conference of the Cardiac Unit, which consists of cardiologists, roentgenologists and the catheterization and surgical teams. The routine work-up as previously described is first presented and then the patient is brought in for a confirmation of the auscultatory findings by aid of a multiple stethoscope amplifier and a review of the phonocardiogram strip. This also affords an opportunity to question the patient. Decisions are then made as to the need for further study, such as catheterization, and as to the necessity for operation, if such decision can be made at the time. For purposes of classifying the need for commissurotomy, the unit has roughly divided this series of mitral stenosis patients into the following four groups:

Group I: Patients who are asymptomatic.

The only manifestations in this group are the diastolic murmur and other auscultatory findings of mitral stenosis; no operation is advised at this stage of the disease process.

Group II: Patients whose main symptom is dyspnea.

This symptom usually occurs upon exertion because of an inability to increase cardiac output sufficiently. In this series, 20 patients fell into this category. Of these, 9 had atrial fibrillation with evidence of peripheral embolization.

Group III: Patients with pulmonary hypertension.

In this stage of the disease, the patients have episodes of dyspnea, cough, pulmonary edema, occasional hemoptysis and all signs of intermittent attacks of left heart failure. In this series, 26 patients were classified in this group.

Group IV: Patients with chronic right heart failure.

The greatly increased pulmonary vascular resistance produces persistent right heart failure, shown by continued elevation of the peripheral venous pressure, increased intrahepatic pressure and other peripheral signs. There were four (4) patients of this type in this series.

TECHNIC

BECAUSE the operative technic for mitral commissurotomy has been described in detail by others, only a brief description of the modification used by our surgical team will be given here. The patient is placed on the operating table so that the left side is up. A posterolateral parascapular incision is made. The pleural cavity is entered through the fourth interspace. Usually no rib resection is necessary, with only two patients in this series requiring it. The heart is next exposed after collapse of the left lung and incision of the pericardium. Pressure recordings may then be made in the pulmonary artery, left atrium and the aorta. This procedure was originally adopted with the hope of obtaining an accurate insight to the degree of mitral stenosis by the size of the pressure gradient between the left

atrium and left ventricle. It was found, however, that these pressure determinations at the time of operation do not necessarily reflect the normal, or, usual pressure for that patient because the anesthesia, the open chest and many other factors have a direct bearing on the cardiac output. These measurements may occasionally be helpful in determining the degree of stenosis and the efficiency of the mitral and aortic valves.

After these preliminary studies have been made, a purse-string suture is put around the auricular appendage. A non-crushing clamp is applied at its base and incision is made into the appendage. The clamp is briefly released to allow a gush of blood to wash out any loosely attached thrombi which might be in the appendage. In our series, 19 patients had well organized thrombi in the appendage. Eight of these had free clots in the auricular appendage. In the remaining 23 cases, the thrombi were diffusely adherent to the endocardium.

Next step in the operative procedure is introduction of the index finger through into the auricle itself and the exploration of the mitral valve. Commissurotomy is then done either by finger fracture or, if the valve is fibrous and calcified, by the introduction of a guillotine knife with splitting of the stenosed valve down to the myocardial wall. The finger is next withdrawn into the auricle. After a period of rest, it is reintroduced through the valve, exploring the left ventricle, particularly the chordae tendinae. If these are found to be fused, they are carefully separated, either by direct pressure of the index finger or, if necessary, by the introduction of a hook knife.

It is not enough just to insert the index finger into the auricle, hurriedly and superficially going over the mitral valve, stretching it somewhat, and then hoping for a satisfactory functional result. A commissurotomy must be done carefully, with meticulous attention to every detail. The stenosed valve should be opened to its full extent. The chordae tendinae, which play an important role in the proper closure of the valve, should be thoroughly explored and separated, if fused. This is done to simulate better the normal functional anatomy. In this series, 33 of the 50 patients showed a variable degree of deformity, scarring or fixation of the chordae tendinae.

The estimated diameter of the mitral valve opening in this series of cases varied between 4 and 10 millimeters. An appreciable amount of calcification was present in 9 cases, minimal calcification in 20 cases. None was found in 19 patients. A regurgitant jet of varied force was felt in 13 patients. Thirty-six of the patients were operated upon during chronic atrial fibrillation. No direct relationship between the heart rhythm and the ultimate result of the operative procedure has been observed by us.

SUMMARY AND CONCLUSIONS

1. Our experience in the surgical treatment of fifty cases of symptomatic mitral stenosis of significant degree is presented. There was no operative mortality.

2. Much progress has been made in the surgical correction of mitral stenosis, with quite acceptable mortality and morbidity attached to the procedure.

3. First step toward the proper treatment of a patient with mitral stenosis is correct and definite diagnosis of the cardiac lesion or lesions, starting with careful evaluation of the symptoms, murmurs and baseline diagnostic procedure. Further procedures are then carried out as indicated. Evaluation for mitral commissurotomy can best be done by clinicians, radiologists, surgeons and those engaged in performing special physiologic studies working as a team, reviewing all patients before the procedure is done.

4. New Jersey is fortunate in that it now has several centers in various areas of dense population where patients may be studied without great financial burden, and without the inconvenience of a long trip from home.

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The Changing Scene in the Mental Hospital

One of the promising possibilities of tomorrow's psychiatry is the conversion of the public hospital doctor from the status of inn-keeper to the status of captain of a rehabilitation team. A distinguished British psychiatrist tells how this can be accomplished.

Mental hospitals have been designated to serve two major functions: (1) care and treatment for patients suffering from mental illness; (2) protection of the public from anti-social behavior resulting from mental illness. This inevitably has aligned the mental hospital with two different and not necessarily parallel developments of function. There has been a semblance of the prison about the mental hospital: custodial care and legislation resulting in a disciplinarian role for the nursing staff with locked doors and restrictive fences to prevent the escape of the patient. On the other hand with the introduction of "physical" treatment and the development of laboratories for biochemical and pathologic investigations, there has been a tendency to develop along the lines of a general hospital.

The mental hospital, although a hospital in name, has to provide for vastly different needs from that of the general hospital. Sickness in terms of bed treatment and nursing care is almost negligible within a good mental hospital, and frequently less than 5 per cent of the total hospital population have illnesses which require bed care.

The other 95 per cent, unlike patients in general hospitals, are ambulatory. Provision has to be made for a hospital atmosphere which would best meet their social and cultural needs and be most likely to help them improve to the point of being able once again to live in the ordinary community. The particular emphasis placed on these aspects of function within the hospital has, to a certain extent, been dependent not only on the administration of the mental hospital but also on the attitude of the general public.

Enlightened men such as Gardner Hill, Brown, Connelly, and Tuke in Great Britain and Isaac Raye, Elias Todd, Amariah Brigham and Samuel Woodward in the United States were the early leaders in the "moral treatment" of the mentally ill. Their writings reveal a great sense of empathy, understanding and humanitarianism in their approach to their patients. Moral treatment was a way of life offered to the mentally sick under the direction of physicians whose concept of mental illness was based on high valuation of the individual and belief in his recuperative powers. It was an effort to create a favorable environment in which recovery could take place.

These were men who deplored the use of mechanical restraint and emphasized the need of social and cultural activities within the hos-

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pital and the need to treat their patient with trust and understanding. Theirs was a philosophy which presumed mental illness to relate to difficulties in interpersonal relationships and the necessity for management which would take into account the fact that apart from their mental illness they had assets and features of normality which required the provision of an environment within the hospital not dissimilar entirely from an ideal environment outside.

DURING this period (1830 to 1850) there was a remarkably high recovery rate. Dr. Parks' writing on follow-up results at the Worcester State Hospital indicates that 70 per cent of first admissions who had been ill for less than one year were discharged recovered, and that only approximately 20 per cent relapsed.

At this time the mental hospital was a small unit and the staff of the hospital consisted of personnel who gave a great deal of their own personalities toward producing an atmosphere within the hospital which was less restrictive.

Toward the latter part of the 19th century, however, community attitudes to mental illness and the zest and zeal of reformers seemed to alter. Mental hospitals increased rapidly in size. Large numbers of people were admitted which led to overcrowding. Community emphasis leaned more towards the exclusion and lack of tolerance of eccentricities in behavior. The emphasis was on legislation towards certification of the mentally ill with adequate measures for the prevention of the escape of patients and more permanent measures for the protection of the public.

Mercier in *The Improvement of Lunatic Asylums* (1894) emphasized the dangers that may arise from the interningling of the sexes particularly in such places as the kitchen or the laundry. He wrote of measures which could be introduced which would more effectively prevent suicides and escapes from the hospital, such as the advantage of iron bars for windows, armored plated glass and steel screens which could stand the pressure of thousands of pounds.

This change in attitude and its consequent reduction in the number of discharges at the Worcester State Hospital in 1880 resulted in the provision of an unnatural prison-like atmosphere. This made the provision of suitable psychiatric management very difficult.

At that time in Britain the only way of admission to a psychiatric hospital was by certification. This inevitably meant that people sought psychiatric advice only when mental illness was fairly advanced or when their behavior was so disturbed that they simply had to be removed from their family setting.

Mental hospitals became more and more isolated from the community as a whole. There was a tendency to build new hospitals far away from local communities. Mental hospital staffs became isolated from their colleagues in other spheres of medicine and out of touch with the psychologic problems and emotional conflicts that lead to breakdown in mental health.

TODAY, in the more enlightened countries it is becoming slowly realized that mental illness is not synonymous with "madness." If the proper atmosphere is provided in the mental hospital and if community attitudes toward mental illness are healthy attitudes, then disturbed, aggressive and violent behavior is the exception rather than the rule. In a good mental hospital the number of violent and aggressive patients is usually less than 1 per cent and the need for measures of restraint is no longer present.

This has necessitated a change within the hospital toward the lessening of restrictive measures and greater permissiveness and freedom. The development of an atmosphere of this nature within a mental hospital is easier than it was in the days of "moral treatment." Recent advances in physical treatment and the development of tranquilizers have assisted in the management and treatment of the acutely disturbed mentally ill to such an extent that, within a short period after admission, acutely disturbed behavior is rarely seen. Much of the aggressive anti-social behavior of chronic patients and the increasing withdrawal and re-

gression, are now thought to be contributed to by restrictive measures, isolation and unawareness of the patients' needs.

There remains, however, the difficulty of coping with very large populations in mental hospitals. The size of the hospitals is a legacy of an era when protection for the public was emphasized as the greatest need in relation to the management of the problem of mental illness.

In England and Wales the movement towards abolition of restrictions and the early management of mental illness was stimulated by the introduction of legislation in 1930 permitting the admission of voluntary patients to mental hospitals. This enabled people for the first time to express a wish to have treatment.

More recently greater contact between the psychiatrists in mental hospitals and the general public, and changed community attitudes have resulted in an increasing number of patients being admitted on a voluntary basis. In several hospitals in England and Wales, the total of voluntary admissions numbers more than 90 per cent. In Gloucester, no admissions within a 20-mile radius of the hospital have been on a certified basis over the past year, and difficult behavioral problems are dealt with on the basis of a short-term order which may last from 3 to 28 days. In no instances in these cases has it been necessary to certify patients with the elapse of the short term order, 84 per cent remaining as voluntary patients. The overall voluntary admission rate is 96 per cent.

The reduction of restriction within the hospital and the development of a therapeutic atmosphere has required change of emphasis of roles within the hospital, re-orientation of inter-personal relationships and organization and classification in social, recreational and occupational spheres.

In Britain at least five hospitals, admitting all types of psychiatric problems and responsible for all types of psychiatric disturbances have managed to run efficiently without additional danger to the public, without the need for keys, locked doors and fences. These hospitals are now completely open hospitals, and the reciprocal trust developed between patients and staff and the increased permissiveness and freedom provided, have done much to establish within these hospitals an extremely high hospital morale and the type of atmosphere which seems most conducive to mental health.

The opening of doors and the abolition of restriction could not have been introduced without proper organization of the hospital prior to the removal of restrictions. Adequate classification of patients along behavioral lines and organization of patients into small groups for which the total day has been planned, precedes the opening of the hospital doors and is an essential facet in the development and integration of the hospital community. *Pari passu* with these changes is the need for social and cultural activities and the change of roles within the hospital. By providing a platform for group discussion at all levels throughout the hospital structure including patients, medical and nursing staff, as well as technical, administrative staff and other people participating in the functioning of the hospital, it has been possible to deal with the insecurities produced by the change in role and to integrate and cement better inter-personal relationships between these various groupings who tend to guard their own prestige and privileges jealously. By these methods, general apathy and resentments have been changed into energetic, active participation and a healthy approach to problems. This has encouraged better social-interaction and patients have taken more responsibility in hospital management and contributed more to social, cultural, occupational and recreational activities within the hospital. That this is feasible within a short period of time despite the limitations produced by deficiencies in personnel is evidenced by an experiment which was carried out in Gloucester (England) recently, which resulted in the conversion of a completely closed mental hospital into an open door hospital within six

months. Twelve months later inquiry shows that patients and staff would be unwilling to return to restrictive measures even if it only involved locking one or two wards within the hospital.

Sedation has been markedly reduced; physical assaults have been entirely absent and aggressive behavior between patients has been reduced very markedly. Seclusion is hardly necessary and has dropped from 236 incidents of seclusion within six months to 10 in a corresponding period. Escapes have been limited to approximately one per week — not markedly in excess of elopements prior to the opening of the doors of the hospital. No instances of violent or aggressive behavior towards the public have occurred. There have been only three instances of minor disturbances in relation to the community, all of which was tactfully dealt with. Considering that the census of the two hospitals is approximately 1400 this is probably no more than would occur in a random sample of the community as a whole. Measures of this nature, however, cannot be carried out without considerable improvement in hospital community relationships and the education of the community towards a more healthy attitude to mental hospitals and the mentally ill.

It is necessary to provide accommodation which is esthetically pleasing for recent admissions within the mental hospital. The press and the police are important in influencing attitudes and producing pressure which may result in the return of increased restriction and the isolation of the mentally ill.

A large proportion of the psychiatrist's time is now spent in working in general hospital out-patient clinics; seeing patients in their homes with general practitioners, and discussing emotional aspects of their problems with colleagues in other specialties and in general practice. Closer contact between the psychiatrist and the general practitioner is necessary. This ensures that those general practitioners interested in psychologic factors producing symptoms can refer to the psychiatrist, readily reaping the benefit of his teaching and thus gaining better insight into the problems of his practice. Closer links are also necessary between the psychiatrist and health officers and social agencies. There is need to educate public health nurses, school nurses, school teachers, ministers of religion, supervisors in factories and the general public. Close integration is necessary between psychiatric services provided in mental hospitals and welfare services, so that as a result of joint consultation a healthy relationship can be fostered and institutionalization and isolation in mental hospitals reduced. Whilst the psychiatrist is spending much of his time outside the hospital in the community, much benefit can be reaped by bringing ancillary workers and the general public into the mental hospital. This enables them to understand better how a mental hospital functions and helps them appreciate the degree of normality of many mental hospital patients, thus assisting in the provision of a therapeutic social and cultural atmosphere within the hospital.

In many British mental hospitals a League of Friends plays a useful part in providing additional patient comforts and benefits, promoting good public relations, assisting in occupational and recreational activities and in facilitating of rehabilitation. Chronic patients have been taken on daily outings and entertained by Women's Institutes members for tea. Members of the League of Friends have come into the hospital to organize camera clubs, gardening clubs and other club activities. Personnel skilled in the teaching of domestic science have helped mentally ill housewives to recover or retain their ability to cope with household duties while in hospital. Occupational therapists and psychiatric social workers have usefully participated in group meetings and discussions which enable better social interaction between staff and patients, and the maintenance of closer liaison between patients and their families.

This means that the extent of isolation produced in the mental hospital has been diminished. The degree of dependence of the chronic patient, on the hospital, is also reduced and

he is better fitted for return to the normal community.

An interesting experiment at Netherne Hospital (England) has shown that discharge from a mental hospital may relate more directly to the proximity of the residence of the patient to the mental hospital than to any other factor. The greatest number of chronic patients in the hospital came from areas far removed, where the patient's family had either disintegrated or lost interest and shelved their responsibilities on to the State.

This then is the changing scene in the mental hospital with the development of an atmosphere within the mental hospital community which is of therapeutic benefit to the patient, facilitating easy return of the patient to the community, and producing more enlightened attitudes on the part of the public so that illness produced by psychologic causes can be more readily recognized, tolerated and treated early. In this way the mental hospital is becoming a base for treating the mentally ill not only by physical and psychotherapeutic measures, but by assisting in re-orientation of their attitudes and motives, and preparing them for improved inter-personal relationships.

In the process of the management of mental illness there are many half-way houses which can assist either in early management or in gradual rehabilitation. These are out-patient clinics, day hospitals, night hospitals, the annexes and mental health centres and social clubs which should be closely linked with the mental hospital and enable ready referral and interchange of facilities.

As a result of cooperation between sociologists, epidemiologists and psychiatrists, and close integration of welfare and psychiatric social services and education of the community, many patients destined to spend their lives in mental hospitals may be able to return and spend happy and useful lives in the community. This, together with the advances in psychiatry for the treatment of the acutely excited behavior states, is beginning to halt the ever-increasing number of patients admitted to mental hospitals which more than doubled between 1929 and 1954.

Tuberculous Meningitis Without Injections

Ten consecutive unselected cases of tuberculous meningitis in children were treated alternatively with a combination of streptomycin, isoniazid, and p-aminosalicylic acid (Group A) or with isoniazid (Group B). There were two deaths, one in each group. The eight survivors have been followed for three years. All are well except one case in Group A who has a mild hemiplegia and is mentally retarded. Results with isoniazid by mouth as the sole method of treatment are as favorable as those obtained under the more orthodox treatment. Treatment with isoniazid is much simpler. No injections are required. This is a particularly welcome feature with children.

*Sweetman, W. P. and Sykes, C. G. W.: Journal of Diseases of Children, 92:2 (July, 1956)

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Chlorothiazide as a Diuretic and Hypotensive Agent

The search for a safe and potent hypotensive-diuretic continues. The Beth Israel group here reports encouraging results with a new chloro-sulfamyl-benzo-thiadiazine product.

IN RECENT years the physician has been fortunate in having several diuretics at his disposal for the treatment of congestive heart failure. Even the most popular of these have had several drawbacks. The orally used organic mercurials have had poor absorption, toxicity and gastro-intestinal intolerance. The parenteral mercurial preparations have had the disadvantages of inconvenience, local pain and nodules at the site of injection, muscle cramps, prostration and intermittent diuresis. Carbonic anhydrase inhibitors such as acetazolamide (Diamox®) have been disappointing at times because of the low potency, frequent refractoriness and the creation of an electrolytic imbalance. Reports of Novello and Sprague,[1] Russo and co-workers[2] and Baer *et al.*[3] with chlorothiazide† (6-chloro-7-sulfamyl-1,2,4-benzothiadiazine-1,1-dioxide) revealed that this might be an oral, non-mercurial diuretic with promise. This prompted us to start a clinical investigation with this new agent in April 1957.

This investigation ended in December 1957 and the results were reviewed a month later.[4] Much of the data is now known to the profession. It is not our purpose here to dwell too long on the diuretic effect of chlorothiazide but rather to discuss our preliminary studies on the hypotensive effects of the drug, especially, when combined with reserpine. This study was stimulated by the early reports of Hollander and Wilkins[5] and Fries and Wilson.[6] We used a double-blind technic to eliminate the bias and enthusiasm which may affect the patient and physician.

PHARMACOLOGY

Chlorothiazide† produces inhibition of carbonic anhydrase with an order of activity between that of sulfanilamide and acetazolamide.[7] In reference to electrolytic excretion patterns, a single oral dose of 2 Grams gives a characteristic response. Among the cations, the increase in sodium excretion was greatest. Potassium excretion was temporarily increased while ammonia excretion was moderately decreased. Of the anions, chloride excretion revealed the greatest increase and bicarbonate excretion increased only transiently. The magnitude of the electrolyte excretion varies with the size of the dose. Other pharmacologic studies[8,9,10,11] revealed that chlorothiazide has properties combining those of carbonic anhydrase inhibitors and mercurial diuretics. It is only a moderate carbonic anhydrase inhibitor with the following initial effects: (1) early increased sodium excretion, (2) increased potassium excretion, (3) minimal bicarbonate excretion. The potassium and bicarbonate excretion occur to a much smaller extent than with the classic carbonic anhydrase inhibitors. Metabolic acidosis as a complication of diuretic therapy with chlorothiazide is unusual. The sub-

*This work is from the Cardiac Clinic of the Newark Beth Israel Hospital. In addition to Dr. Becker, the co-authors are Franklin Simon, M.D., Arthur Bernstein, M.D., Sanford Lewis, M.D., Frederick Weiss, M.D., Walter Nudelman, M.D., Milton Shoshkes, M.D., Aaron Finkelstein, M.D., Frederick Wachtel, M.D., Arthur Perelman, M.D., William Karlen, M.D., and Normand Solomon, M.D.

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†The chlorothiazide was supplied under the tradename of Diuril® by Merck, Sharp and Dohme's research laboratories at West Point, Penna.

sequent diuretic effects of the agent are similar to the mercurials with the chloride excretion paralleling the sodium excretion. Because of the principal action of excreting sodium and chloride, the drug has been referred to as a saluretic-diuretic agent.

Upon oral administration, the onset of action is within 2 hours and the duration of action is 6 to 16 hours. The oral route is more effective for increasing the total 24 hour excretion of sodium than is the rapidly excreted intravenous route. Although, by the intravenous route, the onset of sodium excretion occurred earlier, the duration of the effect was shorter and therefore the total 24-hour excretion was smaller.

The activity of chlorothiazide is due to a direct influence on renal tubular electrolyte transport. There is no effect on renal blood flow or glomerular filtration rate. Although chlorothiazide has a tubular effect, perhaps limited to the distal tubule,[12] the method of action by which it blocks the renal tubular absorption of electrolytes is not fully defined. Nor has the mode of action by which chlorothiazide exerts an antihypertensive response been clearly elucidated.

CHLOROTHIAZIDE IN CONGESTIVE HEART FAILURE

Fifty patients were studied in the Cardiac Clinic of the Newark Beth Israel Hospital. They were treated from 4 to 28 weeks (Table 1). The series (Table 2) included 11 patients with rheumatic heart disease, 21 with arteriosclerotic heart disease, 5 with hypertensive heart disease, 8 with hypertensive-arteriosclerotic heart disease, 1 with idiopathic myocarditis, 1 with Paget's heart disease and 3 with arteriosclerotic-pulmonary heart disease. They were all in classification III according to the criteria of the New York Heart Association. The duration of the congestive failure varied from one to ten years. All were ambulatory, adequately digitalized, presumably on a low salt diet and 46 of the patients had had additional diuretic therapy. Only 4 patients with recently discovered congestive heart failure had never had previous diuretic therapy. Four patients had previously been maintained on chlormerodrin (Neohydrin®) exclusively. Eleven patients had been maintained on optimum doses of oral diuretics combined with parenteral mercurials every 3 to 4 weeks. Ten patients had previously required parenteral mercurials every 2 weeks either alone or combined with oral diuretics. The remaining 21 patients had required parenteral mercurials daily, 3 times per week or 2 times per week either alone or combined with oral diuretics (Table 3).

TABLE 1.
DURATION OF CHLOROTHIAZIDE† THERAPY

Weeks	No of Patients
25 - 28	11
21 - 24	15
17 - 20	5
9 - 12	10
5 - 8	6
4	2

Total patient weeks of therapy = 881

TABLE 2.
ETIOLOGIC CLASSIFICATION

Rheumatic heart disease	11
Arteriosclerotic heart disease	21
Hypertensive heart disease	5
Hypertensive arteriosclerotic heart disease	8
Idiopathic myocarditis	1
Paget's heart disease	1
Arteriosclerotic-pulmonary heart disease	3

TABLE 3.
PREVIOUS DIURETIC THERAPY

None (recently discovered cases)	4
Chlormerodrin (Neohydrin®) only	4
Parenteral mercurials every 3-4 weeks combined with oral mercurials or acetazolamide (Diamox®)	1
Parenteral mercurials every 2 weeks alone or combined with oral diuretics	10
Parenteral mercurials daily to weekly alone or combined with oral diuretics	21

Baseline studies such as previous weights over the prior 3 months, chest x-ray, electrocardiogram, blood counts and routine chemistries and urinalysis were ordered. Electrolyte studies were done in selected cases. Previous diuretic therapy was discontinued and chlorothiazide† 0.5 Grams twice daily as the initial dose was substituted. The patients were seen frequently at the onset to determine the status of their heart failure clinically. In most cases this was weekly, although some had to be seen more frequently. The usual symptoms of congestive heart failure were reviewed and the signs such as rate, rhythm, blood pressure,

gallop rhythm, rales, effusions, distention of neck veins, hepato-jugular reflux, liver enlargement and peripheral edema were noted. Further radiographic studies, electrocardiograms, and blood studies were ordered when indicated. Determination of subsequent dosage of chlorothiazide† and subsequent interval of attendance at the clinic was made by individualized clinical evaluation in each case.

RESULTS AND DISCUSSION OF DIURETIC STUDY

THERE was a reluctance to accept advance reports and so we entered into clinical investigation with subdued enthusiasm. Two patients, however, dispelled our initial doubts. One was a 39-year old woman with heart disease who had recurrent bouts of pulmonary edema every 5 to 10 days in spite of parenteral mercurials three times weekly plus chlormerodrin (Neohydrin®) orally daily. Finally, in desperation, we gave this patient chlorothiazide† in May 1957. There was an initial diuresis of 800 cubic centimeters one night. Since then, there has been no recurrence of pulmonary edema in 28 weeks with a regimen of chlorothiazide,† 500 milligrams twice daily and mercurial injections weekly. The second patient was a 65-year old woman with Paget's heart disease who was mercurial fast, receiving meralluride (Mercuhydrin®) three times per week plus oral chlormerodrin (Neohydrin®) daily. She was unable to lose weight, remained in constant respiratory distress and was afflicted with severe abdominal cramps, diarrhea and hemorrhoids. On chlorothiazide,† the response was striking with a weight loss of 3 to 7 pounds; improvement in cardiac status and loss of toxic symptomatology. She has been comfortable for 26 weeks on a regimen of chlorothiazide,† 0.5 Grams twice daily and parenteral mercurials every 2 weeks. Following the remarkable improvement in these 2 patients, we embarked on a more ambitious program of investigation.

The average dose of chlorothiazide† was 0.5 Grams twice daily with a 6 to 12 hour interval. Forty of the patients required this amount and many were allowed a 2-day rest period on weekends. Three patients required one Gram twice a day, 4 patients used 0.5 Grams three times daily, 2 used 0.5 Grams daily and 1 patient needed only 0.5 Gram every other day (Table 4). Apparently, the sensitivity to the drug varies and the effective dose may thus range from 0.5 Grams every other day to one Gram twice daily. Each patient must have an individualized dose. Doses higher than 2 Grams daily were usually no more effective. Ford, Moyer and Spurr [10] noted that chlorothiazide exhibited a rising dosage response curve as the amount given increases from 0.5 to 2.0 Grams daily. This is similar to the dosage response curves shown by the mercurial diuretics and is in contrast to the flat curve of the classic carbonic anhydrase inhibitors.

TABLE 4.
CHLOROTHIAZIDE† DOSAGE REQUIREMENTS

Dose:	Pts.
0.5 Grams every other day	1
0.5 Grams daily	2
0.5 Grams twice daily	40
0.5 Grams three times daily	4
1.0 Grams twice daily	3

One soon learns the responsiveness of the patients. Should they return with marked weight loss and complain of weakness, leg cramps and parasthesias, the dose should be reduced or rest periods be introduced on weekends. One should always be on guard for early symptoms of electrolytic disturbances. We rarely give the second dose after 4:00 p.m. in order to allow for a complete daytime diuresis and allow the patient to have an uninterrupted restful night.

Results with chlorothiazide† on the elimination or diminution of other diuretics were gratifying (Table 5). There were 35 patients in this series who required no other diuretics. These included four recently discovered cases, the four patients who had been maintained on oral mercurials alone and what is more significant, 27 patients who had been on parenteral mercurials either alone or combined with other oral diuretics. Six patients in the series needed mercurials parenterally once a month or less. This was usually necessitated by dietary indis-

cretion or superimposed respiratory infection. We are certain that several of these patients might have been handled by increasing the dose of chlorothiazide† temporarily and we have been doing that successfully, now that we have accumulated greater experience with the drug. Six patients still were receiving parenteral mercurials in a reduced dose. These were extremely sick patients who had formerly been getting parenteral mercurials from daily to 3 times per week.

One of the most important effects of the potent oral diuretic was the smooth continuous diuresis. There was less fluctuation in the weight and symptomatology. An important observation was the marked diminution in the number of acute episodes of congestive heart failure such as paroxysmal dyspnea and pulmonary edema. This welcome effect prevented strain on the part of the patient and wear and tear on the weary physician who attends these patients. There were 5 such patients in this series where episodes of pulmonary edema had been prevented for from 12 to 28 weeks.

In three patients there was no satisfactory response. One patient had severe rheumatic heart disease, another had arteriosclerotic heart disease with the possible complication of constrictive pericarditis and the third had advanced arteriosclerotic cardiovascular disease. Poor patient cooperation might explain the first failure whereas the latter two were cases that were in the terminal stages of their disease.

TABLE 5.
RESULTS OF CHLOROTHIAZIDE† REGIMEN ON THE USE OF OTHER DIURETICS

		Pts.
No other diuretics needed		35
Recently discovered cases	4	
Previously on parenteral mercurials alone or combined with oral diuretics	27	
Previously on chloromerodrin only	4	
Occasional parenteral mercurials*		6
Parenteral mercurials in reduced dosage		6
No satisfactory response.		3

A response was considered *excellent* if there was a total replacement of other diuretics and improvement in signs and symptoms. A response was considered *good* if there was a reduction in the dose of parenteral mercurials and improvement in the signs and symptoms or if there was a total replacement of the parenteral mercurials and the signs and symptoms remained the same. The response was considered *fair* if there was a reduction in dose of parenteral mercurials and the signs and symptoms remained the same. The response was deemed *poor* if there was no reduction in the dose of parenteral mercurials or improvement in signs and symptoms. Reference to Table 6 reveals that the response was considered excellent in 29 patients, good in 17 patients, fair in 1 patient and poor in 3 patients.

TABLE 6.
CLINICAL RESPONSE TO CHLOROTHIAZIDE† REGIMEN

	Pts.
Excellent—(Total replacement of other diuretics and improvement in signs and symptoms)	29
Good—(Reduction in dosage of parenteral mercurials and improvement in signs and symptoms	11
or	
total replacement of parenteral mercurials and signs and symptoms the same)	6
Fair—(reduction in dosage and signs and symptoms same)	1
Poor—(no reduction in dosage of parenteral mercurials or improvement in signs and symptoms)	3

In the 40 patients who had an excellent or good result relative to symptomatology, the response to the diuretic produced a weight loss between 3 to 8 pounds. This is significant in that this was below the optimum response to previous diuretic therapy.

Another important clinical observation with chlorothiazide† is that we have encountered no patient who once responsive to chlorothiazide† later developed resistance to it. This is in contrast to classic carbonic anhydrase inhibitors.

These findings lead one to compare chlorothiazide† with the diuretics already used. In the majority of patients it appeared as potent a diuretic as parenteral mercurials and indeed in some patients it was effective when parenteral mercurials failed. It appears to be more

*Once a month or less.

effective than any other oral diuretic used currently. Ford and co-workers[9] in carefully titrated experiments, determined that one Gram of orally administered chlorothiazide† produces an increased sodium excretion comparable to a cubic centimeter of meralluride (Mercuhydrin®) administered intramuscularly. Four tablets of chlormerodrin (Neohydrin®) are comparable to 0.5 Grams of chlorothiazide† administered orally. This dose of chlorothiazide† is roughly twice as potent as the optimal dose of acetazolamide (Diamox®). Other interesting comparisons[13] have been noted between chlorothiazide,† carbonic anhydrase inhibitors and mercurial diuretic agents.[14] Chlorothiazide† produces effects within 2 hours which persist for approximately 12 hours. The main effect is a significant increase in sodium and chloride excretion. The increase in potassium excretion is about one-half of that of sodium. As a compensatory renal mechanism to conserve sodium, ammonia excretion is increased during the second 12-hour period. The excretion rate of bicarbonate is about one-fourth that of chloride. With acetazolamide, on the other hand, the immediate response is augmentation of sodium excretion with an almost equal effect on potassium and bicarbonate. Chloride excretion is suppressed during the period of greatest bicarbonate loss but it increases when the latter subsides. Probably because of the relatively small sodium loss ammonia excretion is not altered. The onset of action occurs within 6 hours and lasts for 6 to 12 hours. Following an injection of a mercurial diuretic, the onset of action occurs within 2 hours, reaches its maximum in 2 to 6 hours and lasts for 12 to 18 hours. An increased excretion of sodium and chloride is the predominant effect. Potassium excretion is not significantly altered. Ammonia excretion, slightly depressed at first, becomes elevated after the period of greatest sodium loss. During the stage of greatest chloride loss, the bicarbonate excretion is suppressed, but returns to normal or higher which the chloruretic response subsides. Thus, it can be seen that the initial effects of chlorothiazide† appear to simulate those of acetazolamide and the later effects to mimic those of the classic organic mercurial agents. Whereas chlorothiazide† simulates excretion patterns of the other diuretics, the mechanism of action is probably different.

Toxic reactions were few in this series, at the time that the formal study was terminated and reviewed. At that time, reactions were noted in only 3 patients and they were transient. They consisted of dizziness, weakness, occasional nausea, vomiting, epigastric pain, paresthesias and leg cramps. They had occurred in those patients who were extremely responsive to the drug and were immediately obviated by reduction in the dose without loss of clinical control. No hematologic, renal, hepatic or skin complications were noted in this series. Further experience, however, in other patients not included in the series revealed extreme weakness in few, marked vomiting and gastric intolerance in some no matter how the dose was reduced, and finally one patient has been seen with a diffuse erythematous eruption and desquamation which could be attributed to chlorothiazide.†

Chlorothiazide† is a potent diuretic and is capable of producing electrolytic imbalances including hypochloremia, hypokalemia and alkalosis, especially with prolonged use. In this series, one patient with hypochloremic alkalosis was noted. In addition, she had an accompanying hypokalemia. This was corrected by temporary cessation of therapy and the introduction of potassium chloride into the regimen. The hypochloremic alkalosis might also have been treated with ammonium chloride but this was unnecessary. In general, it is our feeling that hypochloremic alkalosis may be avoided by the judicious adjustment of dosage, by avoidance of too strict salt restriction, interruption of therapy and by prevention of excessive chloride loss due to vomiting which may occur with digitalis intoxication. Lately, we have also been advising the use of salt substitutes, not so much for the palatability of the food but because they provide potassium chloride in amounts which tend to counteract the weakness and other effects of potassium loss.

As yet, we have seen no case of low salt syndrome although we are certain to find one sooner or later, what with the prolonged use of the drug, hot weather and marked salt restriction which is apt to occur. Another interesting point to remember is that this drug does not produce a metabolic acidosis and therefore may be used with impunity in patients with impaired renal function, which frequently accompanies hypertensive heart disease.

Finally, it is important to recognize that diuretic therapy is only one important facet in the therapy of cardiac failure and does not obviate the necessity of adequate digitalis administration, rest and nutritious diet.

There were 4 deaths in our group. Three were sudden (myocardial infarctions) and one resulted from pulmonary emboli. These could in no way be related to the therapy used and seemed to be the usual average for the calibre of the patient that was under observation.

CHLOROTHIAZIDE† IN HYPERTENSION

Following the publication of the enthusiastic reports of Wilkins and Hollander [5] and Fries and Wilson,[6] we decided to appraise the hypotensive action of the drug. We first reviewed our original experience in the series of patients with congestive heart failure. It was obvious immediately that the drug was not hypotensive in the normotensive individual with heart failure. This had been noted by Fries *et al.*[16] Of the 13 patients with congestive heart failure due to hypertensive or hypertensive arteriosclerotic heart disease, 8 revealed no change in blood pressure, 3 patients had a significant drop in blood pressure and 2 patients showed elevation of blood pressure. Since blood pressure changes in congestive failure are not uncommon no matter what the diuretic to bring it under control, we felt that patients with severe congestive failure were not suitable ones for testing the hypotensive effect of chlorothiazide.† We, therefore, embarked on a program of investigation, choosing those hypertensives with no evidence of congestive heart failure. To decide if this drug potentiated the effect of other hypotensive agents, we chose those patients who had previously been primed with reserpine until the blood pressure was stable. To this regimen, we added chlorothiazide† (0.5 Grams twice daily) using a double blind technic. We realized that there are certain inherent handicaps even in this approach; namely, that the patient or investigator soon might be able to tell the difference between placebo and the drug because of side reactions and that one might be unable to titrate the drug individually and therefore, have to select an arbitrary dosage schedule. In a double blind test, there is no way to circumvent these difficulties but it was still our feeling that this method maintained more objectivity than would have been the case otherwise.

Observations were made on 45 essential hypertensive patients seen every 2 weeks at the Cardiac Clinic of the Newark Beth Israel Hospital. The patients were classified in the following manner: Grade I—*Mild*—Systolic blood pressure below 200 and diastolic blood pressure below 100 with retinal changes of mild narrowing and sclerosis of the retinal arteries; Grade II—*Moderate*—Systolic blood pressure 200 to 220; and diastolic blood pressure between 100 and 120 with moderate retinal arteriosclerosis and arteriovenous nicking; Grade III—*Severe*—Systolic blood pressure 220 to 280 and diastolic blood pressure 120 to 140, accompanied by angiospastic retinitis with exudates, hemorrhages and spastic sclerotic arteries. By this classification, 12 patients were in Grade I; 29 in Grade II; and 4 patients in Grade III. No patients with malignant hypertension (Grade IV) were included in the series. All the patients had hypertensive electrocardiographic changes as evidenced by a left ventricular strain pattern or, at least, large "U" waves in the precordial leads. The ages of the patients varied from 27 years to 76, with the vast majority falling between the ages of 50 and 70. Fifteen of the 45 were males. The patients had been primed with reserpine for a minimum of 2 months. Casual blood pressures were recorded in the sitting or standing position, the lowest of several readings over a 3 to 5 minute interval being charted. The blood pressures were con-

sidered stable before the patients were placed on the test regimen. All had been on some dietary restriction of salt, and remained on their previous dietary regimen. The period of observation ranged from 2 to 6 months with an average of 14 weeks.

RESULTS

Before deciding on the value of a procedure it is important to decide on criteria for a significant drop in blood pressure. We adopted two criteria for this: (1) a sustained reduction in the mean blood pressure of 20 millimeters or more; or (2) drop in the grade of hypertension according to the above classification. Such amelioration of the disease process, if sustained might herald a better long term prognosis.

It was noted that 30 patients (70 per cent) revealed a drop in blood pressure, and 13 patients (30 per cent) had either no change or a rise in blood pressure. Two patients were unable to take the drug because of gastric intolerance. Using the above criteria of *significant drop* in blood pressure, it was noted that only 19 patients (44 per cent) had a significant drop in blood pressure.

The average blood pressure of all the patients before institution of chlorothiazide† therapy was 203/110 with a mean blood pressure of 156. Following therapy the average blood pressure was 181/100 with a mean of 140. This amounts to an overall percentage drop in systolic blood pressure of 12 per cent and a diastolic drop of 9 per cent. The drop in mean blood pressure was 10 per cent. See Table 7.

TABLE 7.
CHLOROTHIAZIDE† IN RESERPINE-PRIMED HYPERTENSIVES

	Systolic	Diastolic	Mean
Before chlorothiazide† (average)	203	110	157
After chlorothiazide† (average)	181	100	140
Percentage fall in blood pressure	11.8	9.0	10.2

In 19 patients (*i.e.* 44 per cent of the series) there was a clinically significant fall in blood pressure.

COMMENT

This is the largest group of patients to be reported in which only the combination of reserpine and chlorothiazide† was used. It demonstrates that there is a definite potentiating action of chlorothiazide.† The *significant drop* in blood pressure in 19 patients (44 per cent) attests to its value in the out-patient treatment of hypertensive disease. Whether this drop will be sustained over a long period of time remains to be seen. Although a certain amount of enthusiasm is warranted, it will be tempered in the crucible of time.

The mode of action by which chlorothiazide† exerts an antihypertensive effect has not been clearly elucidated. Long before the first papers published in this country on the potentiating effect of chlorothiazide,† Smirk [17] made the observation that anything that will dehydrate the body, whether it be diarrhea, vomiting, excessive sweating or the use of diuretics, would have the tendency to potentiate the dose of ganglionic agent used. This would lead to the logical conclusion that the effect may be related to sodium depletion, having an effect akin to the rice diet [18] or other low sodium diets.[19] If this is so, then the patient may have the benefits of the rice diet without having to go through the rigors of it; an example of having your cake and eating it too. Heider *et al.*[20] agree with this concept and feel that it is unlikely that the response to chlorothiazide† is a direct reaction of the drug. They postulate that through its diuretic action, there is a decrease in total blood volume which might make the other drugs more effective. The reduction in total body sodium due to increased secretion of salt could explain the potentiation. Sodium certainly plays some part in hypertension. The work of Dahl and Love [21] revealing the close relation between the incidence of hypertension and the high level of sodium intake underscore this fact. Other data gained from work with other diuretic agents and salt excreters reveal [20] that they also enhance the hypotensive effect of the commonly used antihypertensive agents. Wilkins [22] postulates that decrease in the pressor substances (such as renin by chlorothiazide†) is a possible explantion of part of its action, especially during its continued use,

when its primary diuretic effect seems either to become compensated or dissipated. Fries [16] and Wilkins [23] say that this is the only hypotensive drug that performs only in hypertensives and thereby has some specificity of action, other than its saluretic effect. The above discussion leaves this open to question.

Our experience with the use of chlorothiazide† as a potentiator of ganglionic blockers is limited because of the limited number of patients in Grade III or IV that we have in the clinic and it is this group that we usually reserve for ganglionic blockade. In the limited experience of patients in private practice, it was found that there is a definite necessity for reduction in the dose of the ganglionic blocker. The side effects still exist but not as frequently and the spikes and troughs of blood pressure variation seem to be smoothed out.

Fries *et al.*[16] noted an 11 to 16 per cent decrease in blood pressure (in 35 patients) over and above the previous regimen with ganglionic blockaders. Heider *et al.*[20] reported ten patients in whom the blood pressure reduction was of such magnitude as to require a decrease in the dose of the ganglionic blocking agent. In addition, they had 8 patients in whom there was a significant drop in blood pressure where the dosage did not have to be altered. Another group of 9 patients who were previously unresponsive to mecamylamine, remained unresponsive following the addition of chlorothiazide.† The average blood pressure reduction in the first 18 patients varied from 23 to 28 per cent. Blood pressure reduction was greatest in patients who lost the greatest amount of weight.

CONCLUSIONS

1. Chlorothiazide† is a potent orally effective minimally toxic, non-mercurial diuretic-saluretic agent.

2. It is the most effective oral diuretic agent available.

3. In 50 patients in severe congestive heart failure, parenteral mercurials were discontinued in 60 per cent of the patients.

4. Chlorothiazide† may cause a diuretic response in some patients who are apparently refractory to mercurials.

5. The optimum dose in most patients in severe congestive heart failure is 0.5 Grams twice daily.

6. Chlorothiazide† is an effective antihypertensive agent and appears to potentiate reserpine in the treatment of the hypertensive state.

7. Forty-five hypertensive patients on a previous regimen of reserpine to which chlorothiazide† was added revealed an overall drop in systolic pressure of 12 per cent, diastolic pressure of 9 per cent and mean blood pressure of 10 per cent beyond that obtained with reserpine alone.

8. A clinically significant diminution in blood pressure occurred in 19 patients, or 44 per cent of the series.

9. Sustained amelioration of hypertension on this regime will be judged by prolonged study.

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The Prevention and Treatment of Prematurity*

The pediatricians, it is said, have gone as far as they can in the prevention of prematurity. It is now a problem for obstetricians and general practitioners who take care of pregnant and prepregnant women. The authors here list a practical program for prematurity control.

One of the most important problems facing obstetricians is the prevention of prematurity. Prematurity is the major cause of perinatal mortality.[1] If we could prevent prematurity, we could practically eliminate perinatal mortality. The incidence of prematurity remains somewhat constant at just under 10 per cent.[2] In New York City for the year 1956, prematurity accounted for 8.5 per cent of all births. This less than 10 per cent incidence is responsible for two-thirds of the perinatal mortality, one-half of the fetal mortality and three-fourths of the postnatal mortality. The magnitude of the problem is underlined by the associated high morbidity in those prematures who survive. The need for further medical care is four times greater in premature infants than in term infants.

Formerly prematurity was considered a pediatric problem and there have been many advances in the pediatric management of the premature newborn. However, even with these advances, maternal mortality is falling faster than perinatal mortality. Between 1946 and 1953, for example, perinatal mortality declined 19 per cent while maternal mortality declined 44 per cent. Today we realize that a multidisciplined approach is essential with emphasis on the role of the obstetrician. A most recent report by Rider *et al.*[3] indicated very little difference in survival rates of premature infants whether cared for at hospitals conforming to the highest standards or at hospitals rated below par in premature management. Survival rate was low even in the high ranking hospitals. Premature babies who did survive had a higher than average incidence of handicaps. They concluded that increased emphasis and support should be given to methods of preventing or delaying premature births. What can doctors do to further this concept of prophylaxis? Any answer to this pertinent question must be predicated on an understanding of the factors influencing incidence and etiology.

General Factors

General factors which predispose to prematurity include age, parity, race, economic status, diet and prenatal care. In the past fiscal year at Metropolitan Hospital there were

*Read November 26, 1957 before the Academy of Medicine of New Jersey. This work is from the New York Medical College (Metropolitan Medical Center).

360 premature births in 4033 deliveries, an incidence of 9 per cent. The highest incidence was in the young primipara under 20 years of age. This predeliction for the young patient has been reported by Hacker,[4] Morrison,[5] and Marchetti and Menaker.[6] Since all our patients are Puerto Rican, no conclusion can be drawn about the influence of racial factors. However, most reports agree that the incidence is higher among Negroes than among whites even adjusting for the fact that Negro newborns weigh less than white newborns for the same period of gestation.[7]

In our series, two-thirds of the patients had inadequate (or no) prenatal care. Prenatal care was considered inadequate if the patient had two visits or less. Eastman[8] and Hacker[4] reported that 50 per cent of the cases in their series could be thus classified as having no prenatal care. Related to the adequacy of prenatal care, I am sure, is the higher incidence in ward patients as compared to private patients.[9] The importance of proper nutritional status has been emphasized by many investigators.[8,10,11,12] With the evidence supplied by Eastman[8] and corroborated by others, there is a growing belief that premature labor can be traced in many instances to defective maternal diet. In an excellent British study[13] of effects of diet, the reduction in incidence of premature births in groups given dietary supplements was statistically significant. It may be this rather than racial factors that is responsible for the increased incidence of prematurity in Negroes. Differences in nutritional status would also help to explain the differences in incidence between ward and private patients. It is apparent that prenatal care, diet, economic status, emotional status and racial factors are all interdependent.

A somewhat more controversial issue is the relationship of smoking to prematurity. According to Simpson[14] the incidence of premature births is two times greater in smokers than in non-smokers. He correlates the premature rate with the number of cigarettes smoked daily. In his series, Mexicans reportedly had the lowest incidence of smoking, and also the lowest incidence of prematurity.

SPECIFIC CAUSES

THE specific factors associated with premature labor in our 360 cases are shown in the table.

SPECIFIC CAUSES ASSOCIATED WITH PREMATURE BIRTH

Cause	No.	Per Cent
Toxemia	46	12.8
Multiple pregnancy	36	10.0
Antepartum hemorrhage	11	3.1
Elective cesarean section	4	1.1
Medical and gynecologic complications	16	4.4
No specific cause	247	68.6
Total	360	100.0

Toxemia of pregnancy was the most significant maternal factor with 46 cases or 13 per cent. This is considerably higher than our clinic average of 7 per cent.[15] Multiple pregnancy was the second most frequent factor accounting for 36 cases or 10 per cent. Antepartum hemorrhage of all types was associated with 11 cases, 3.1 per cent. Elective cesarean section done too early contributed 4 cases. This seems to be a small but definite factor in the incidence of prematurity. Other complications combined were responsible for 16 cases; less than 5 per cent.

No specific maternal factor could be demonstrated in over 60 per cent of the cases.[8] While improved management of the specific causes as outlined above should be associated with a decrease in the incidence of prematurity, the 60 plus per cent group showing "no cause" remains a challenge for study and research.

PRECONCEPTIONAL CARE

A REAL advance is the concept of preconceptional care or fetal salvage clinics. This is prophylaxis at its best. Two such clinics[16,17] now in operation report favorable results in a high proportion of patients. In our series, as in others, one-third of the patients gave a history of prior premature labor. These patients are particularly suited for work-up in the preconceptional clinic. The most significant findings amenable to therapy are varying degrees of endo-

metrial insufficiency and abnormalities of the uterus. In certain cases of repeated premature labor, Jeffcoate and Wilson[18] and Lash and Lash[19] have demonstrated an incompetency of the internal os. They recommend an operative repair with the hope of preventing repeated premature labor. The procedure is usually done between pregnancies. However, if this condition can be diagnosed during the pregnancy, purse string suture around the dilated cervix may be taken in an attempt to prevent rupture of the membranes and the onset of premature labor and thereby gain more time *in utero* for the fetus. The reported results are promising. This concept of incompetent internal os and its repair is surely a step in the direction of positive prophylaxis.

ANTEPARTUM CARE

For the woman already pregnant, improved prenatal care is essential. Particular attention should be paid to the vulnerable group of unwed, non-white primipara under 20 years of age. By bringing early, skillful and improved prenatal care to these women, we can reduce the incidence and degree of prematurity. Good antepartum care includes proper management of medical complications plus counselling in regard to rest, exercise, nutrition and emotional factors. It should be recognized that the public health nurse, nutritionist and social worker may each make a contribution.[20]

PREMATURE RUPTURE OF THE MEMBRANES

There is no available method for the prevention of spontaneous premature rupture of the membranes. When it occurs, conservatism is essential and may be rewarded with extra time *in utero*. The latent period between rupture of the membranes and the onset of labor is directly proportional to the length of time between rupture of the membranes and expected date of confinement. The pregnancy should be allowed to continue without induction. Antibiotics are indicated to decrease the chances of perinatal loss from intrauterine fetal infection.

MULTIPLE PREGNANCIES

The incidence of prematurity in twin pregnancy is extremely high, ranging from 55 to 65 per cent. The associated complications of toxemia and anemia frequently seen with multiple pregnancy also affect the fetal outcome. Success has been reported following a regime of hospitalizing women with twin pregnancies at 33 weeks. Apparently the onset of premature labor in these patients is associated with the erect posture of the human female. By increasing bed rest, the onset of labor may be delayed. Thus the key note of prevention of prematurity associated with multiple pregnancy is early diagnosis which will allow for better management of the pregnancy, labor and delivery.[21]

PLACENTA PREVIA

With general acceptance of the conservative management of placenta previa as advocated by Macafee[22] and Johnson,[23] fetal loss from this complication can be reduced from 50 to 10 per cent. The essentials of this conservative treatment include hospitalization, blood replacement as indicated and careful observation while giving the fetus further chance to mature. This has been one of the real advances in the prevention of prematurity.

TOXEMIA

Improved prenatal care should be associated with a decrease in the incidence of toxemia of pregnancy. The newer antitensive agents may permit better control of the disease with a chance for further fetal development. However, in toxemia, the obstetrician is faced with a dilemma. Many of the infants do not grow *in utero* and spontaneous intrauterine death is an ever present danger. In addition, the

active therapy indicated for control of the toxemia may necessitate termination of the pregnancy on maternal basis irrespective of fetal size. Therefore, it is important to prevent the occurrence of toxemia if we hope to affect the fetal outcome.

CESAREANS

If one follows the concept, once a cesarean section always a cesarean section, it becomes his responsibility to avoid delivering a premature infant. Every modality must be used to estimate fetal size including, if necessary, x-ray of the abdomen. Since this factor must definitely be classified as controllable and preventable and since it is notoriously difficult to be sure of fetal size, it may be that by awaiting the initiation of true labor before proceeding with elective repeat cesarean section we can further prevent prematurity.

ERYTHROBLASTOSIS

In problems of erythroblastosis fetalis, premature induction presents a double hazard. The combination of prematurity and isoimmunization is associated with an increased morbidity and mortality. In selected cases showing an increasing titer and bad history, "preterm" induction may be indicated.

MEDICAL COMPLICATIONS

Intensive prenatal care for patients with medical disease with liberal use of hospitalization for proper control particularly in diabetics and cardiacs, is essential. This will improve fetal outcome by preventing premature labor in some and eliminating the need for therapeutic interruption in others. In diabetics, proper medical care is directed to the prevention of ketoacidosis and superimposed toxemias. Diabetic pregnancies should be terminated at 36 to 38 weeks. These babies in spite of their large size must be treated as premature infants.

SPECIFIC TREATMENT

Many cases of premature labor will occur unrelated to the above mentioned maternal factors and in spite of all efforts to control these factors. What can we offer the patient if premature labor does ensue even though she has had adequate prenatal care and proper attention to all complicating factors? The usual steps in management include bed rest, sedation and hormonal therapy. The limited value of bed rest and sedation is understandable. The value of hormonal therapy is controversial. All have been used including thyroid, estrogen, progesterone and more recently Relaxin®.[24,25] Thyroid has fallen into disuse although still prescribed on an empirical basis. Progesterone has passed through phases of enthusiasm, rejection and reinterest. Advocates of such therapy believe failure in some hands is due to inadequate dosage. Newer interest has been stimulated by the availability of long acting products and newer progesterone-like compounds of greater activity. It is too soon to draw conclusions but these newer products give evidence of being more helpful in abortions than in management of premature labor. We have been evaluating Relaxin® at our institution for the past three years. Relaxin® is a purified non-steroid hormone of pregnancy obtained from sow's ovary. It was discovered in 1926 by Hisaw[26] and noted to cause pelvic relaxation of the estrogen primed guinea pig. On the basis of experimental and animal work carried out by several investigators, the effect of Relaxin® has been studied in cases of premature labor. Abramson and Reid[27] in one of the first studies reported success in arresting premature labor in 5 patients. Folsome[28] and his co-workers reported arrested premature labors in 57 per cent of a group of 40 patients. More recently McCarthy *et al.*[29] using Relaxin® for threatened premature labor, concluded that it did inhibit premature labor in uncomplicated cases without rupture of the membranes. Our intensive studies over the past 3 years failed to corroborate these reports. Paradoxically, current studies by ourselves and others involve the use of Relaxin® to hasten or induce labor.

Until clinical obstetricians can agree on an exact standard for the onset of true labor, it would be difficult to credit any specific agent with the ability to stop labor. Undoubtedly many of the successful reported cases were patients in false labor or having severe Braxton Hicks contractions. Another argument against the efficacy of Relaxin® in the treatment of premature labor is the multiple number of causes as above described. Even if Relaxin® did everything claimed for it, it would be contraindicated in premature labor secondary to such complications as abruptio placentae. At present we regretfully conclude that hormonal therapy is not effective in reducing the incidence of prematurity.

What can we do if premature labor occurs in spite of all attempts at prevention and treatment? Here only the strictest adherence to the principles of proper management of labor and delivery will improve fetal outcome. Our aim must be to prevent anoxia to the vulnerable vital centers of the premature infant. There is general acceptance of the following principles.

Analgesia and anesthesia should be kept to a minimum. Regional anesthesia is the agent of choice. Inhalation anesthesia is to be avoided. Delivery should be effected over a wide episiotomy to lessen the resistance of the pelvic floor. Outlet forceps are indicated to shorten the second stage of labor. In breech presentation, spontaneous delivery should be permitted so as to lessen the chances of the incompletely dilated cervix clamping down around the after-coming head. Vitamin K is administered to the mother in labor and to the infant at birth. The newborn's air passages should be aspirated and a clear airway established. Oxygen is administered and warmth provided. Prophylactic antibiotics are indicated and the infant is transferred to a premature nursery where adequate and experienced consultation should be available. It is strongly urged that a pediatrician be in attendance at the delivery.

CONCLUSIONS

WHAT more can we do to reduce the appalling figures of 150,000 deaths a year? From the pediatric viewpoint an irreducible minimum has almost been reached. More often than not, the longer the fetus remains *in utero,* the better the chance for survival after delivery. Further fetal salvage therefore rests on a maternal approach both preconceptional and prenatal. The conclusion is inescapable that defects in diet are closely associated with prematurity. Such defects can be detected and corrected with better prenatal care. In efforts to improve prenatal care all agencies must cooperate fully including medical and public health groups. The concept of preventive obstetrics must be emphasized.

Advances in preventive care will depend on further research. Basic research must be encouraged in the problems of habitual abortion, endocrine dysfunction, uterine dysfunction, placental physiology and nutritional factors.

As clinicians we can complement the research activities by continued emphasis on prematurity at scientific meetings and hospital staff conferences. Perinatal mortality conferences should receive wide staff support or be instituted if none exist. The efforts of special groups such as the Special Committee on Infant Mortality of the New York County Medical Society and the Committee on Maternal and Child Care of the American Medical Association indicate that there is a high level of activity and interest in the problems of prematurity. These activities give hope that further progress in the management of this problem can be expected.

Flower and Fifth Avenue Hospitals

A list of 29 citations appears in the authors' reprints.

The Role of Insurance in Meeting the Costs of Medical Care

III. New Protection Against Major Expenses

WHERE do people turn when their illness expenses go beyond the scope of the usual health insurance policy? A new form of insurance—using the deductible approach and providing sums up to $10,000, or even $20,000—appears to be the answer.

The two previous articles in this series sponsored by the Joint Conference Committees of The Medical Society of New Jersey and the Health Insurance Council* have outlined the basic principles of health insurance and discussed the customary forms of protection: insurance against loss of income and against hospital, surgical, and regular medical expense. But the protection provided under the customary hospital, surgical, and regular medical policies was not designed to meet the expenses of those who are hospitalized for long periods; of those whose surgical bills substantially exceed the amounts provided in the schedules of surgical insurance policies; of those who require extensive treatment by non-surgical specialists; or of those who need special nursing care or expensive drugs outside the hospital. Although relatively few people have such extreme expenses, they can be financially disastrous for those who must pay them.

To give protection against these expenses, a new type of policy has been developed within the last decade. The purpose of this third and final article in the series on health insurance is to explain the characteristics of *major medical expense insurance,* how it is sold, and what it means to physicians.

MAJOR MEDICAL EXPENSE INSURANCE

MAJOR medical expense insurance is characterized by high maximum limits, broad coverage, a deductible feature, and a coinsurance clause.

The new policies provide a choice in maximum benefit limits ranging from $2,500 or $5,000 to as high as $20,000. They cover practically every expense, in or out of hospital, necessary to restore the sick or injured person to health. Coverage is so broad, in most cases, that the cost of treatment not yet thought of will automatically be included within the policy's terms. Occasionally internal limits will be found—for example, no more than a specified daily amount for a private room in a hospital—but usually the only limit on individual items is that they be "reasonable charges for necessary services." There is no financial pressure for the patient to demand or the doctor to prescribe one form of treatment rather than another.

Such broad coverage presents two major problems: the frequency of minor illness and the subjective character of much illness. It is to meet these problems that major medical expense policies generally contain a deductible provision and a coinsurance clause.

Eliminating the Small Claims: Deductibles. The deductible provision eliminates small claims and also the disproportionate administrative expense associated with them. It takes substantially as many claim forms, filled out by the physician and reviewed by the company, to process small claims as large ones. Although these small claims represent a large element of cost in the aggregate, minor bills can be readily taken care of by the insured and

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should be provided for by budgeting rather than through insurance. By excluding small bills from this new form of insurance, it is possible for the major medical premiums to remain at an attractively low level and for the insurance dollar to be used to best advantage in covering the larger elements of expense that can be such a hardship to the individual.

The deductible amounts commonly range from $50 to $500. The higher the deductible, the lower the premium. The policies generally provide that, in the case of a common accident affecting more than one insured person in the family, the deductible of only one of them shall apply to the combined expenses of those hurt in the accident.

Some insured persons want to take care of the smaller claims directly from their own funds, while others rely in part on the basic policies described in the previous articles to fill the gap. In working out the proper deductible for the particular case, it is desirable for both the prospective insured and the insurance company to take into account any basic benefits previously purchased. Otherwise, in certain claim situations the insured would be paying for and receiving double benefits, thus destroying the principle of the deductible.

Subjective Nature of Illness: Coinsurance. The provision in this new type of policy of large aggregate amounts, running as high as $20,000, clearly brings into focus the subjective character of many illnesses.

Every physician knows of cases where one person is so sick that he thinks he should go to the hospital, while another, with the same condition physically, thinks he is well enough to go to work. The different reactions to the same situation are affected, not only by an individual's impression of his own sickness but also by such things as his previous relations with his physician, his present relations with his family and his employer, and his financial situation.

Financial worries can contribute to illness and retard recovery; on the other hand, the certainty that treatment is available without substantial expense may encourage a person to seek unnecessary treatment or prolong treatment. It is undesirable that lack of money should prevent proper treatment. But unnecessary treatment for many people, due to the presence of insurance, will increase the cost of the insurance, possibly to the point where it would be a heavy burden for people to buy it. The companies have tried to solve this dilemma by introducing a financial sharing on the part of the patient, known as "coinsurance." The patient pays from his own funds not only the deductible but also a percentage of each additional dollar spent for his medical care. Generally the insurance company's share above the deductible is limited to 75 per cent of the expenses, with the patient paying the remaining 25 per cent. The patient thus has a direct financial interest in each dollar of medical or hospital care ordered for him.

HOW MAJOR MEDICAL EXPENSE INSURANCE IS SOLD

MAJOR medical has had the most rapid growth of any type of health insurance. By the beginning of 1957, less than eight years from its conception, major medical protection was held by nearly nine million people. It is estimated that approximately thirteen million people had this type of protection by the end of 1957.

Policies Sold to Individuals. While policies are available with maximum benefits as low as $2,500 and as high as $20,000, the policies most commonly sold have maximums of $5,000 or $10,000. Deductibles in these policies range from $200 to $750 or even $1,000. The $500 deductible is the one most frequently selected. Some companies require that applicants in higher income brackets select the higher deductibles.

Pre-existing conditions are usually excluded from the coverage under all forms of individual insurance because this merchandising method does not furnish the broad cross section of risk available in group underwriting. An interesting departure from tradition has been taken by some companies which do not incorporate a general exclusion of health conditions existing at the time the insurance is purchased. In such instances, care must be taken, of course, to see that those insured are in fact

in good health at the time the policy is issued. The company may exclude by a rider attached to the policy any specific condition of the applicant which makes him a substandard risk. This same technic may be used to exclude an uninsurable dependent, thus making it possible for the rest of the family to be insured.

Another method now gaining growing acceptance, is to provide full coverage at a higher than normal premium. Substandard underwriting of health insurance can be accomplished in much the same way as substandard underwriting of life insurance. As statistical data on the results of substandard underwriting accumulate, this method of providing health insurance for persons with less than normal health may be expected to become more prevalent. Even now, the use of exclusion riders is lessening.

The maximum age at which major medical expense insurance will be written is slowly increasing. Most companies will issue this coverage up to age 65, although some set lower limits. Once issued, policies are generally renewable beyond the issue age limit, some having no set age limit for renewals.

A few companies offer non-cancellable guaranteed renewable major medical policies. This coverage generally ceases, however, at age 65, or is renewable thereafter only at the option of the company. However, even when companies reserve the right to cancel or refuse renewal, it is becoming increasingly common, either as an underwriting practice or as a policy provision, for them not to exercise this right simply because of deterioration in health.

Another growing practice is for companies to guarantee renewal but reserve the rights to increase premiums by class. This assures the policyholder that even if his health should deteriorate to the point where he is no longer insurable, he will nevertheless be able to continue his coverage on the same basis as more fortunate individuals with the same policy. At the same time, the company protects itself against unforeseen losses brought about by inflation, depression or other events affecting the whole economy.

Normal *exclusions* in individual policies are maternity (except unusual complications); dentistry (except as may be required as the result of accident); the cost of care in a hospital which does not normally render bills (such as the Veterans Administration Hospitals); expenses arising as a result of war and the care of persons in the Armed Forces; job-connected injuries (already paid for under Workmen's Compensation Insurance).

Mental and nervous disorders (by and large "functional" rather than organic) may also be excluded. More and more companies, however, are removing this exclusion, although they may require that the expenses in such a case be incurred in a hospital.

The exclusion of the ordinary maternity expenses from the major medical policy is an example of the purpose of major medical expense insurance. The maternity expenses are relatively uniform and relatively minor, and can be anticipated in family budgeting for several months prior to delivery.

Insurance Offered to Groups. Most of the major medical insurance now in force has been sold to groups. These group policies may be of a conventional sort, purchased by a single employer for his employees; or they may be industry-wide groups, under which an association of employers, or a union is the contract holder. Through this latter method, many employers, too small to qualify for group insurance on their own, may join with other small employers in the same line of business in providing funds for group benefits.

Group insurance can be issued with fewer restrictions than individual insurance because it is possible through the group approach to obtain a broader cross section of risk. Thus, employees, if actively at work and willing to subscribe at the time the coverage is first offered to them, are covered regardless of existing medical conditions; and dependents are likewise covered unless they are in the hospital or are undergoing treatment.

In addition, group insurance is cheaper because it is sold by the mass merchandising method and the employer collects the employee's share of the premium through payroll deduction. The employer's share of the premium is itself a most important factor in

reducing the cost to the individual. One company reports:

> Approximately 28 per cent of our cases are on an employee-pay-all basis, 22 per cent involve an employer contribution to the premium of less than 50 per cent and 50 per cent involve an employer contribution of 50 per cent or more of the premium.

The latest development in group major medical expense insurance is the introduction and growth of *comprehensive* insurance. Major medical was originally thought of as taking over, subject to deductible and coinsurance, after benefits under a basic hospital and surgical plan were exhausted. In comprehensive major medical, the deductible and coinsurance provisions apply to the first dollars of expense. The deductible, often expressed as a percentage of the employee's wages rather than as a specified sum of money, may be as low as $25. While there is always some difficulty in introducing such a plan to a group which has been accustomed to first dollar benefits, employees generally are not slow to realize the advantages of the greater protection afforded by this type of plan.

The exclusions under group insurance—either supplementary or comprehensive—are about the same as under individual insurance except that expenses of mental and nervous disorders are generally as eligible for reimbursement under group insurance as any other type of illness. Some plans are written so as to increase the employee's coinsurance share of the expenses in disease of this character from 25 per cent to 50 per cent. Such a provision may be requested on the ground that nervous and mental disorders are in many cases quite subjective, and it is unfair to load on either the employer or the fellow employees the cost of psychiatric treatments obtainable on a continuous basis "after hours." As indicated above, the group method of underwriting removes the necessity of excluding pre-existing conditions.

MAJOR MEDICAL AND THE DOCTOR

ALL types of health insurance place a considerable responsibility upon the doctor. The payment of benefits depends largely on the physician's professional judgment. Physicians have it in their power to determine not only whether benefits shall be paid, but to a large extent how great the benefits shall be. This is particularly true in major medical coverage, where there is often no limit on payments inside the maximum amount other than "reasonable charges for necessary services."

Insurance neither multiplies dollars nor reduces aggregate costs. Thus, physicians should not regard the presence of this insurance as increasing the public's "ability to pay," but rather should recognize that insurance is a convenient method of spreading costs among self-supporting individuals, *and that any aggregate increase in costs for the whole insured population will merely be reflected in increased premium rates.*

This is not to say that increased usage of medical facilities or increased costs due to more effective but more expensive medical procedures is not desirable. One of the reasons for developing all forms of health insurance was to remove the fear of the financial consequences of a serious illness and thus encourage the prospective patient to seek early preventive care. Nor is the attainment of this objective meant to deny to physicians, and to other providers of services in the health field, a normal up-grading of income along with the rest of the population in inflationary times. Rather, it is an expression of confidence, based on past experience, that fees and charges will not rise just because of the presence of insurance.

Physicians have seen many advantages in major medical coverage, particularly in the comprehensive policies carrying a low deductible, with the co-insurance factor applied to all expenses above that amount. What insurance experts see as a return to basic insurance principles, doctors see as a further release from financial restraints on the practice of medicine, making it possible to prescribe expensive drugs, nursing care, and hospitalization as required by the patient's physical needs without causing financial catastrophe. The conventional forms of health insurance, which now cover such a great part of the population, have done much in this respect; major medical, if it continues its present rapid expansion, can be expected to do even more.

Historical Article • • •

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Medieval Medicine in England

American medical practice owes so much to its Anglo-Saxon roots that this review of medieval medicine in England will provide a new dimension for the understanding of medicine today.

THE conquest of the British Isles by Claudius (A.D. 43) introduced Roman medical practices in the new colony, and the thirty years of "hill fighting" taught the natives new methods of treating injuries.

The Saxons speedily over-ran Britain at the end of the sixth century after the Romans departed. They brought along with them from their Germanic homeland the medical lore which they had inherited from early kinsmen. So, they knew of prescriptions containing herbs, minerals, and animal substances including various secretions and excretions. A tincture of superstition permeated their lore.[1]

The early healers of Germany were largely women and, according to Tacitus, even the wounded on the battlefield were brought to their mothers and wives for medical attention.

The union of the Angles and the Saxons produced an amalgamation of the medical lores of both nations. To this was added, in 597 (when Christianity was introduced in England) the Roman Church medicine as practiced by the monks in Italy.

The name "leech" is derived from the Anglo-Saxon "laece" meaning "to heal." The word *dom* means "a law." The word "leech" became applied to a physician because the doctors originally specialized in phlebotomy and used the leech for blood letting. English leeches do not appear to have belonged to the priestly cast as did the Druid healers before them. The last were priests who employed magic arts and other superstitious means in their healing practices.

When the Christian Church became firmly established on the Isles, medicine became sponsored by the ecclesiastics. Gibbon in his "Decline and Fall of the Roman Empire" says that one of the most powerful causes of the spread of Christianity was the miraculous healing powers of the primitive Church . . . Indeed, so acclaimed were the healing powers of the Church that the third century witnessed the rise of a special order of men within the Church whose function was to cast out demons from persons stricken with disease.[2]

That there was some kind of training in the art of medicine available in England in the early Middle Ages may be inferred from the following lines written by an author of that period.

> "Twig runes shalt thou ken
> If thou a leech will be,
> And ken a sore to see;
> On bark shall one then write
> And on branch of wood whose
> limbs to east do lout."

In the Anglo-Saxon work, *Medicinale Anglicum,* the expression is frequently met with "as leeches know how," from which it may be inferred that the leeches were professionally trained persons. The early training of the

English leech might have been in the monastic infirmaries.

"One of Theodore's pupils," writes the venerable Bede, "was called in to see a young priest who had suffered a concussion of the brain in consequence of a fall from his horse. Through the efforts of this ecclesiastic, the priest regained consciousness." John of Beverly, however, sent for a leech to attend to the priest's injuries. The latter splinted the bones and bandaged the fractured skull.[4]

THE status of the leech in the seventh century is reflected in Bede's *Ecclesiastic History*. He alludes to ecclesiastics who performed minor operations and phlebotomy. Leeches were subordinate to Church healers. Bede mentions the Saxon leech Cynfrid, who attended Setheldryth, the Abbess of Ely, in 579 during her last illness. He lanced a carbuncle on her neck.

The following narrative shows that the ecclesiastics consulted lay physicians on surgical matters: A boy who was dumb, came one day to solicit alms from the Bishop, St. John of Beverly. The boy had scabs and no hair on his head. The Bishop taught the patient how to speak (evidently he was not a mute) but did not try to cure the boy's ailment. He called in a professional leech to treat the skin condition and a complete recovery ensued.

We owe to the "venerable Bede" the first description of the plague in England in 664. This epidemic is supposed to have been brought from Ireland where it had raged during the previous year.

Bede is said to have been the author of a work on phlebotomy entitled, *De Minutione Sanguinis Sive de Phlebotomia*. Bede gives the particular days and the time of day most propitious for bleeding. He warns that no bleeding should be performed on certain unlucky days. He states, "Any time by day or night needs we must use phlebotomy in acute diseases and especially in the time from the eighth of the Kalende of April to the seventh of June, we have good results from taking away blood because then the blood is undergoing an increase."

The *Saxon Leech Book* mentions the leeches Bald, Oxa and Dun. That the surgery of these leeches was not confined entirely to salves, poultices and plasters, is evident from the following extract: "For hare-lip, pound mastic very small, add the white of an egg and mingle as though dost vermilon: cut with a knife with silk, then smear without and within with the salve ere the silk rot. If it draw together arrange it with the hand. Anoint again soon."[6]

AFTER the venerable Bede there was a 200-year lull in medical progress. Medical literature broke its silence in the person of Bald, who influenced his friend Cild to write the first Anglo-Saxon leech book known as the *Leech Book of Bald* (in Latin "Medicinale Anglicum"). This is the first medical book that was written in Anglo-Saxon. Almost all books in Europe at that period were in the Greek or Latin language.

The *Leech Book* remained in manuscript until 1864 when it was printed in the "Chronicles and Memorials of Great Britain" by the Master of the Rolls. It was then translated into modern English as part of *Leechdoms, Wort-cunning and Starcraft of Early England* —a collection of documents illustrating the history of science in England before the Norman conquest.

The Leechdom of Bald occupies 109 manuscript pages and 299 printed pages. It concerns itself primarily with treatment. The diseases for which remedies are prescribed start with the head and proceed down to the feet.

Medicinale Anglicum begins with a list of the various remedies recommended for affections of the head; next came therapies for ailments of the eyes, ears, throat, parts of the face, teeth, mouth and lips. Coverage then proceeds to affections of the chest (including coughs), the heart, the stomach, the loins, the thighs, the legs and lastly the feet. The thirtieth chapter covers chilblains. Remaining chapters contain prescriptions for tumors, smallpox, skin affections, paralysis, fevers, and snakebite.

The second book concerns itself chiefly with internal and abdominal diseases including those

associated with the stomach, liver, and spleen. It includes some recognition of the signs of disease as well as attempts at diagnosis. It ends with:

"Bald habet hunc librum, Cild quem conscribere iussit.
Hic precor assidue cunctis in nomine Christi
Quod nullus tollat hunc librum perfidus a me
Nec vi, nec furto, nec quodam *famine*[8] falso.
Cui? quia nulla mihi tam cara est optima gaza,
Quam cari libri quos Christi gratia comit."

This may be translated:

"Bald is the owner of this book, which he ordered Cild to write.
Earnestly I pray here all men, in the name of Christ,
That no treacherous person take this book from me,
Neither by force, nor by theft, nor by any false statement.
Why? because the richest treasure is not so dear to me
As my dear books, which the grace of Christ attends."[9]

It would seem from this quotation that Bald wanted this book for his own use. Bald himself might have been a physician who asked Cild, who might have been a scribe or a leech, to write this work. *Medicinale Anglicum* which is of Anglo-Saxon origin, gives evidence that the contemporary leeches were not entirely devoid of learning in Greek and Arabian medicine.

Bald gives classification of the members and limbs of the body and of the diseases to which they are subject. He enumerates remedies for various parts of the body as well as for diseases of the special senses. He applies the apt term "flying venom" to epidemics. The term "venomous swelling" refers to the bubonic plague. Smallpox is mentioned.[10]

Following are some extracts from *Bald's Leechdom*:

"Against pockes; very much shall one let blood and drink a bowful of melted butter; if they (the pustules) strike out, one shall dig each with a thorn, and then drop one-year alder-drink in, then they will not be seen." This last instruction, evidently to prevent pitting, clearly identifies the disease.

Struma was known to the Anglo-Saxon leeches as "neck ratten," or "purulence in the neck."

Yellow jaundice is termed "the gall disease, from which cometh great evil." It is diagnosed when "the patient's body all becometh bitter, and as yellow as good silk and under the root of his tongue there be swart veins and pernicious, and his urine is yellow." The last observation is interesting as being one of the few instances in Anglo-Saxon leechdoms of good clinical observation and reference to the appearance of the urine.[11]

The drinks or potions against poison are very numerous, and are indicative of the dread of poisoning that existed in Anglo-Saxon times —probably because of the current imperfect knowledge of what was really poisonous.

"Against any poison, boil the netherward part of bishopwort and lupin, and the netherward part of springwort, everthroat, and clote in ale; give to drink frequently."

"If an adder strike a man, wash a black snail in holy water, and give to the sick to drink."

One of the most curious remedies reads as follows:

"If a man eat wolfbane, let him stand upon his head, let someone strike him with many scarifications on the shanks; then the venom departs out through the incisions." The belief in demonic possession is evident in this treatment.

That poisonous snakes were common in the land may be gathered from the many leechdoms (however ineffectual) for the bites of adders and snakes:

"Against a hand-worm: take ship tar, add sulphur and pepper and white salt; mingle them together, smear therewith."

"For hand-worms and 'deaw-worms': take dock or clote, such as would swim, mingle the roots with cream and with salt, let it stand for three nights, and on the fourth day smear therewith the sore places."

"Against a boring-worm: let the man eat new cheese, beebread, and wheaten loaf. Again, burn to ashes a man's head bone or skull, put it on with a pipe."

Another variety of worm mentioned is the 'ana worm, which grows in a man." It is referred to as follows:

"If the worm eat through to the outside and make a hole, take a drop of honey, drop it in the hole, then have broken glass ready ground, shed it on the hole, then as soon as the worm tastes of this, he will die." This description seems to fit Dracunculus medinensis—the Guinea worm.

For devil-sickness, for demonic attacks and

for evil eye, the patient is instructed to eat a wolf's flesh, "well dressed, and sodden," and, the leechdom reassures: "The apparitions which ere appeared to him, shall not disquiet him."

"For a man who has the falling-sickness (epilepsy), work to a drink a boar's coillons in wine or in water; the drink will heal him."

For the bite of a mad dog, the following curious remedy is suggested:

"Take the worms which are under a mad hound's tongue; snip them away; weave them around a fig-tree; give them to him that hath been rent; he will soon be whole."

To remove ugly marks from the face, smearing with wolf's blood is recommended, "for it taketh away all the marks."

"For griping," says the leechdom, "let the sick man drink hound's blood; it healeth wonderfully."

A curious relic of the ancient mythology of the Gothic races is apparent in the leechdoms connected with the hound.

The popular medical authorities in England during the fourteenth century may be gathered from Chaucer's "Doctour of Phisik:"

"Well knew he the olde Esculapius
And Deyscorides, and eek Risus (perhaps Ruffus)
Olde Ypocras, Haly and Galyen,
Serapion, Razis and Avycen,
Averrois, Damascion and Constantyn,
Bernard and Gatesden and Gilbertyn."

ANGLO-SAXON SURGERY

JUDGING from the scattered allusions that are to be found in the manuscripts on surgery, it would appear that surgery was not entirely practiced as a separate calling—not withstanding the fact that Bede mentions that "other than the physicians were called in to bleed and scarify."

"For broken head: take betony, bruise it and lay it on the head above; then it unites the wound and healeth." Again, for the same: "Take garden cress, that which waxeth of itself, and is not sown, put it in the nose, that the smell and the juice may get to the head."

Splints were known to the Anglo-Saxon leeches. That they employed them in cases of fracture is evidenced from the following:

"If a sinew shrink (that is, when a leg is broken), and again after that swell, take a she-goat's tord, mingle with vinegar, smudge it on, soon the sinew healeth . . . Then let him (the patient) duly arrange the bones as well as he can, apply a splint, and it is so much the better the oftener a man bathes with the preparation. If a sinew have pulsation, mugwort beaten and mingled with oil, and laid on, is good. Juice of mugwort mingled with rose oil, smear with that; soon will the quaking be stilled."

For bones that are fractured the following treatment is also recommended:

"If the shanks be broken, take bonewort (generally interpreted as violet or pansy): pound it; pour the white of an egg out; mingle these together for the man whose shanks are broken."

Amputation was performed when gangrene set in:

'If a man have a limb cut off, be it finger, foot, or hand, if the marrow be out, take sheep's marrow boiled, lay it to the other marrow, bind it very well at night."

As a dressing for wounds, honey appears to have been generally employed:

"For cleansing of a wound: take clean honey, warm it at the fire, then put it in a clean vessel; add salt to it; then stir it till it is the thickness of pottage; smear the wound with it; then it cleanseth it."

The use of honey as a dressing for wounds goes back to a very early period. Its antiseptic properties were known to the Assyrians many centuries before the Christian era. It was recommended by Hippocrates, and several of the early Greek physicians, in the treatment of wounds.

The Anglo-Saxon leech does not appear to have used mechanical methods for reducing dislocations. In such cases he applied an ointment.

For a hernia, the following treatment is directed:

"If a man's bowels be out; pound gallic; wring through a cloth into milk warm from the cow; wet thy hands therein, and put back the bowel into the man; sew up with silk; then boil him for nine mornings gallic, that is comfrey, except need be for a longer time; feed him with fresh hen's flesh."

That surgery had acquired some degree of importance may be gathered from the fact that an operation for opening an abscess of the liver is described in the *Leechdom of Bald.*

"For hare-lip: pound mastic very small; add white of egg; and mingle as thou dost vermilion (this seems to mean as vermilion is mixed with white of egg for painting purposes)."

The actual cautery or blistering rod was extensively used by the Anglo-Saxon leech. This is evident, not only from the references in the leechdoms, but also from contemporary drawings, which show the form of the instrument, and the methods of its employment. It was apparently used in the preliminary treatment of a variety of diseases, from gout to headache.

"If the edges of a wound are too high (excessive granulations or 'proud flesh'), run them round with a hot iron very lightly, so that the skin may whiten."

Bleeding was practiced with the lancet, the cupping-glass or horn, and the scarifier. Thus, for paralysis, blood is directed to be drawn "with a cupping-glass or horn from the sore deaded places."

It is apparent from this resume that Anglo-Saxon medicine was in a relatively undeveloped state with very little known of anatomy, physiology and methods of diagnosis. Symptoms were treated as diseases and pathology was not known.

Anglo-Saxon treatment was of an herbal nature with the herbs gathered at certain hours of the day or night. Therapy was heavily tainted with charms, spells, and magic potions.

In old Scotland and Ireland the art of medicine was often transmitted from father to son. The oldest of the family were considered most trustworthy to administer to the sick. When a son succeeded his father in the profession, the prestige of the father at once became his own.

The early Anglo-Saxon medical books specifly that only curable cases should be treated. When death seemed imminent or when the patient was in danger of permanent incapacity from illness or accident, practitioners were urged to call in a fellow physician or surgeon to share the responsibility.

A great hindrance to the practice of medicine and a deterrent to its study was the fact that the physician or surgeon, when he failed to effect the promised cure, was often heavily fined or even killed. The death sentence was exacted particularly if the patient died under the operation.

Medicine and surgery were usually two separate branches. Medicine in the larger cities was often controlled by the Church. There were, however, some lay physicians. Surgery was in the hands of laymen exclusively.

Not until the Norman Conquest in 1066 did medicine become a true profession in England. The Norman kings brought along learned ecclesiastics, some of whom had been trained in medicine at the Universities of Salerno and Paris. The influence of the Norman culture and customs made an indelible impression upon the English people. This was particularly true during the reign of Edward the Confessor who chose Baldwin, a French monk, as his personal physician. The Norman kings were the founders of the higher English schools of learning; the first of which was Oxford University.

CAMBRIDGE AND OXFORD

OXFORD University, one of the two greatest seats of learning in England, is a collection of colleges under one corporation on the Thames fifty-one miles from London. It is the oldest house of learning in England and was originally modelled after the University of Paris. It was founded in the early part of the twelfth century in the town of Oxford near the nunnery of St. Friedeswyde and Oseney Abbey. These institutions appear to have been the nuclei around which the University grew up.

Rashdall[12] asserts that the University of Oxford had its origin because of the forced expulsion of English students from Paris (1167) during the political disputes between the English and French sovereigns. "There is a striking relation," says Rashdall,[12] "between the sudden rise of Oxford into a 'studium gen-

erale' (about 1167) and the issue of an ordinance ordering all clerks possessing revenues in England and being residents in France, to return home and forbidding all clerks in England to cross the channel. A large proportion of the clerks holding English benefices and residing in France consisted of students at the University of Paris. It is certain that many English scholars were forced to leave Paris in accordance with this ordinance."[13]

Although 13th century Oxford never ranked with Paris, it was highly honored throughout Europe as a center of classical studies. Modern Oxford University gradually developed out of the schools which existed in Oxford as early as the twelfth century.[16] Theology was the "queen of sciences" at Oxford. The seven liberal arts were looked upon as the handmaids of the School of Theology. Medicine was not included in the liberal arts and the medical school did not have a large attendance. However, lectures in medicine were given at an early date at Oxford. Regulations of the College founded by Walter de Merton in 1264 contain a prohibition against medical students at the College. But this applied only to students who occupied themselves exclusively with medicine.

The study of medicine at Oxford was, at first, only theoretical. Surgery and bedside instruction were viewed as menial labor not compatible with pure scholarship.

A great man who was far in advance of his time and one of the first to value direct observation and experimentation as means of obtaining knowledge was Roger Bacon (1215-1294). Yet even he was often empirical with regard to medical treatment. For a certain malady he recommends a prescription consisting of a pearl and various precious stones exposed to the sun for a given period.

Early in the thirteenth century a definite course of study was established for anyone who desired to become a doctor of medicine. Any candidate for a master's degree was required to have a reading knowledge of the "Tigne" of Galen or one of the books of Hippocrates. No special examination was required for an M.A. to become an M.D. When the candidate presented himself for the license to practice medicine, he had to swear that he had read certain books and the nine regent masters and his preceptor were required to testify to his qualification. Five others had to affirm their belief therein.

The University of Cambridge is in the town and borough of the same name. The first mention of Cambridge University was in connection with the great dispersal which followed the Oxford *Suspendium Clericorm* of 1209. Cambridge University had its origin in the first half of the thirteenth century.

In the prologue of his *Canterbury Tales*, Chaucer presents a picture of the medicine of his period. The physician examining the patient had to ascertain whether the nature of the sickness is cold or warm, moist or dry and which of the four humors produced the malady. After he determined these factors, the prescription was written and the apothecary was called upon to compound it.

Cambridge University, like Oxford, is composed of separate member colleges. The College of Peterhouse, where medicine was taught, was founded in 1282 by Hugh Balsham, Bishop of St. John. The students at first received their instruction in the hospital of St. John. Later Peterhouse was established on the principle of Merton College of Oxford. The medical curriculum differed little from that presented at Oxford and Paris. Both Oxford and Cambridge created licentiates in surgery as well as in medicine, but only the medical graduates could receive a degree. The barber-surgeons of London sent their best scholars to Cambridge and hired able students to lecture for them on surgery and anatomy in order to gain the educational advantages of the University.

The right to license an apothecary student was left to the chancellor who appointed a master to act on his behalf. The prospective druggist had to swear to the following oath before he received a license:

"I swear that I will always have in my shop all medicines, species of medicines and confections

which concern the art and mystery of an apothecary, and are necessary for the health of man."

"That I shall be contented once a year (at least) that certain physicians practicing in the University shall visit my shop upon the account of good and bad medicines, in the month of November, or any other time if occasion shall require it; and these searchers and tryers of medicines being of the Vice Chancellor's and Proctor's appointment, shall have power to destroy and throw away all bad and unprofitable medicines and drugs."

"That I will sell all things appertaining to my trade at a low and reasonable price, and as sold in other places in England."

"That I will not make up any compound medicines without the presence and advice of some physician admitted to the practice who shall judge those samples fit to be made up into compositions."

"That I will observe these things without fraud or deceit."[18]

JOHN OF GADDESDEN (1280-1361)

JOHN of Gaddesden was the first physician to be appointed to the English court. He refers to his father as possessing a choleric temperament and states that he was fond of fruit and milk. He ascribes the formation of a stone which he removed from a salivary gland of his father to this diet.

When John of Gaddesden attended Oxford, a Master of Arts had to study medicine for some four years before being admitted to practice as a Doctor of Physik. However, a practical knowledge of medicine was considered entirely unnecessary. This was in marked contrast to the rigid requirements of contemporary Salerno where practical experience including dissection was a basic requirement.

John of Gaddesden took his degree at Merton College, Oxford, in the early years of the fourteenth century. Having qualified as a Doctor of Physik, he opened his office in London —then a city of about 30,000 population. Besides medicine, he practiced surgery and dentistry. He gave up his general practice when he was formally appointed physician to Edward the Second.

John of Gaddesden wrote a book *Practica Medicina a Capite ad Podem* (1305), commonly known as *Rosa Anglica*, because as a rose has five petals, his book has five parts covering fevers, injuries, general hygiene, diet, and materia medica. John told his readers that as a rose excels all other flowers so his *Rosa* excels everything previously written on the subject of medicine. In truth, however, *Rosa Anglica* contains nothing new. It is a repetition of well known medical works with few original additions. It is replete with superstitious practices. When the young son of Edward II contracted smallpox, John ordered that the prince be swathed in red materials with floor coverings and window curtains in the room all changed to red.[20] The idea that red cures red, and that red surroundings will cure rashes and reduce fever is an old one. Fortunately for John, his princely patient recovered and John prided himself that the son of Edward II was restored to health by his very original and efficient treatment.

John subscribed to the belief that the king's touch cures the king's evil (scrofula). When his own specific—the drinking of the blood of a dove or weasel—failed to cure the patient of king's evil, he recommends that the patient be touched by the reigning monarch. He states that he cured a man who had been blind for twenty years with an infusion of fennel and parsley in wine.

John of Gaddesden had a high opinion of his book. In the preface, he writes: "I implore those who see this book not to gnaw it with an envious tooth but to read it through humbly for nothing is shown here but what is proved." The author was certain that an extract of cuckoo (which bird he said, had an epileptic attack once a month) mixed with boar bladder and mistletoe was specific for epilepsy.

He recommends spikenard in treating dropsy and in his own personal practice, was insistent that this medicine be paid for in advance. In treating colic, he advises the constant wearing of a seal-skin girdle with a whale bone buckle. John of Gaddesden found a cosmetic gold mine in his prescriptions for perfumes, hair washes and hair dyes. He always prescribed twice as much of any drug for his rich patients as he did for his poor ones. He urged physicians to demand their fees before beginning the treatment of a case. In addition to his fame as a prescription writer, he also had some reputation as a poet and grammarian.[21]

John of Gaddesden's book, *Rosa Anglica,* was well written and was held in great esteem by many of his contemporaries. The *Rosa* went through four editions and was popular in Pavia, Augsberg, Venice and Ireland.

Edward Meryon, in his *History of Medicine,* writes that John of Gaddesden was a type of the fourteenth century and an excellent illustration of the tendency of his age. "He glorified in secret practices and was a charlatan of the first order. His remedies, too, were worthy of being recorded as curiosities in medicine. For loss of memory, he recommended the heart of a nightingale and for scrofula, the king's touch. He had the honesty, however, to confess that if the laity did but know his secret, they would despise him and his art."[22]

Until the appearance in 1912 of Chalmley's book, *John of Gaddesden and the Rosa Medicina,* John was almost universally rated as a charlatan. Chalmley, however, evaluates John as follows: "We see therein a man of good education and, as regards his medical education, one who was acquainted with the writings of his predecessors . . . Of anatomy he naturally knew next to nothing; of pathology less."

JOHN OF ARDERNE (1307-1380)

IN THE reign of Edward III, a surgeon of note appeared in England in the person of John of Arderne (John of Arden, 1307-1380). After twenty years of practicing in Newark,* he went to London at the age of 63 where he joined the Guild of Military Surgeons, and where, at the age of seventy, he published *De Cura Oculi.* He developed a lucrative practice among aristocratic and princely families. He was on good terms with the physicians of his day—an almost unheard of thing for a surgeon at that period. He refers to himself with pride as "chirurga inter medicos" (a surgeon among physicians). He looked down upon barbers who practiced surgery.

In contrast with many other medieval literary productions, the writings of Arderne are noteworthy because of the richness of his clinical histories and his preference for rational and relatively simple methods of treatment.

In the treatment of intestinal and renal colic, he used clysters in which a bladder filled with sea water served as a reservoir. Other instillations were recommended by him in bladder and venereal diseases. According to John, "every man should use an enema at least two or three times a year."

John of Arderne always placed his own experience above the dogmatic rulings of surgical authorities. He describes every step of the operations which he presents and he is honest enough to record his failures as well as his successes.

He wrote on the care of the eyes, on bleeding and on sinuses. His only printed work is his treatise on fistula of the anus—a condition that most of his predecessors regarded as incurable. This work deals with fistula in general but chiefly with the origin and treatment of fistula *in ano* to which he devoted special attention. In performing his operation, he first put his patient in a lithotomy position following which he incised the outer wall of the fistula and all of its branches. Bleeding was stopped by pressing with sponges wrung out in warm water. The operated area was then powdered, covered with clean dry pads and held in position by a T bandage. This was in the fourteenth century!

John of Arderne used ligatures to check hemorrhages. He avoided all corrosives in the treatment of wounds. In all operations, he relied upon non-irritating powder and clean dressings for rapid healing.

His method of removing a stone impacted in the urethra is ingenious. He tied ligatures on the shaft of the penis above and below the stone to prevent its slipping. He then made a small incision over the stone and squeezed it out. Following this, he sutured the wound and applied his favorite dressing which consisted of egg white and firmly ground flour. John remarks: "There is no need for alarm in these cases even though the urine escapes from this wound for three or four days after the operation, for the patient will certainly be cured." John's fee for the above operation was 40

*On Trent, not on Passaic.

pounds, and according to John, his patients paid him cheerfully.

John warned his readers of the danger of mistaking cancer of the rectum for simple ulceration. His differential diagnosis between cancer and ulcer of the rectum is that cancer is painless at first and of stony hardness tending to hinder the passing of feces. Later, it ulcerates and causes pain. Still later there is the desire for frequent defecation and the stools are streaked with blood. This was 600 years ago!

He describes the following instruments for rectal operations: a long slender metal probe for examination named *square me;* a broad silver needle with a curved point called *acus rastrata* and a *tendiculum* of wood.

In his *Of Ye Manner of Ye Leeche,* John advises his colleagues to cultivate modesty, charity and chasity. The leech was advised to be particularly careful in his conduct towards the wives, daughters and other women in the house of the patient. "Consider not overopenly with the lady or the daughter or other fair women in great men's houses, nor proffer to kiss them, nor touch their dresses; privately or openly." John advised that the estimated period of time for cure should be increased over the physician's actual opinion for the benefit of the patient and his family. If the patient became well sooner than the prognostication, the leech should tell him that the quick recovery was due to the fact that he was stronghearted, suffered well and was of good complexion; "for such words makes the patient proud."

The surgeon, John suggested, should scorn no one and if another doctor is spoken of, he should answer courteously: "I have nought heard of him but good." He must have clean hands and well-shapen nails which are neither black nor dirty. He should hear much and speak little for if a patient sees that he keeps other people's secrets; he will naturally put more confidence in him. As for fees, John says: "Ask he boldly more or less; but ever be he aware of scanty askings, for over-scarce askings set at nought both the market and the thing."

JOHN OF MIRFIELD (d. 1407)

THE third John of the trio was John of Mirfield (Johannes de Mirfield) a scholastic, who was a cleric of the monastery of St. Bartholomew in London. It is not certain whether he received his medical education in a college or through some form of apprenticeship. He was closely connected with the St. Bartholomew Hospital—perhaps as a chaplain.

John of Mirfield is the author of two medical treatises, the *Breviarium Bartholomei Medicina* (1380) and the *Floarium Bartholomeian Theology* which contains one chapter on medicine. The former is a resumé of contemporary medicine and surgery. He was particularly interested in treatment. There is no theoretical quibbling. In his *Breviarium,* he points out the chief symptoms of ailments which lead to a diagnosis and suggests remedies. Many charms are included. For example, he gives the wording of a charm to be worn by a pregnant woman to facilitate her delivery. He apparently prescribed such charms as a kind of placebo for he did not believe in their therapeutic worth.

The *Breviarium Bartholomei Medicina* (1380), is divided into 15 parts. The first two parts deal with fevers. The next five sections cover diseases arranged according to the regions of the body beginning with the head and proceeding down to the toes. Diseases of the head and throat, the chest, the abdomen, the pelvic organs, and the extremities, are included in that order. The eighth part is concerned with abscesses, the ninth with wounds, the tenth with fractures and the eleventh with dislocations. The twelfth, thirteenth and fourteenth parts deal with remedies, particularly with purgatives. The last section is devoted to hygiene and phlebotomy.

Among John of Mirfield's prognostic signs are many of a superstitious nature in which he, himself, did not believe. For example, if the right eye of a sick man sheds tears, he will die. If the left eye of a woman sheds tears, she will die. If the sole of a patient is anointed with lard and the lard is then thrown to a dog, if the dog eats it without vomiting the patient will recover; on the other hand, if the dog

makes no attempt to eat it or vomits after doing so, the patient will die. These omens are typical of the Anglo-Saxon leechdom prognostics.

John of Mirfield indicts the quacks and particularly "women who usurp this profession to themselves and abuse it." The surgeon is advised to leave the patient alone if he is in doubt about the outcome of an operation: "For it is safer to leave a man in the hands of his Creator than to put trust in surgery or medicine, concerning which there is any manner of doubt."

John of Mirfield did not have a good opinion of his contemporaries: "Modern physicians possess three special qualifications and these are to be able to lie in a subtle manner, to show an outward honesty, and to kill with audacity."

In the following quotation he shows that medicine and surgery were separated in his day:

"Long ago, unless I mistake, physicians used to practice surgery, but nowadays there is a great distinction between surgery and medicine, and this, I fear, arises from pride, because physicians disdain to work with their hands, though, indeed, I myself have a suspicion that it is because they do not know how to perform particular operations; this unfortunate usage has led the public to believe that a man cannot know both subjects, but the well informed are aware that he cannot be a good physician who neglects every part of surgery, and, on the other hand, a surgeon is good for nothing who is without knowledge of medicine."[24]

OLD ENGLISH SURGERY

MEDIEVAL surgery in England was of a minor character and was mostly military surgery performed by guild surgeons or by barber-surgeons. These two groups soon united into a legal corporation which sometimes included physicians and apothecaries and which always constituted the chief licensing body for surgeons in the various towns.

English surgery during the first half of the Hundred Years War was inferior to the French. John of Gaunt, the Duke of Bedford, sought to remedy this defect by making available to English surgeons the writings of Guy de Chauliac in the English vernacular. Guy de Chauliac's skill in treating fractures of the skull and wounds of the breast was supreme. His discreet use of sutures and diet for the wounded restored many to health who might otherwise have died on the battlefield. Quaritch, referring to this translation avers that it is "one of the finest English medical manuscripts in existence."

6917 Atlantic Avenue

A bibliography of 24 citations appears in Dr. Gordon's reprints.

Weather Influence

More mentally defective infants are born in the January-March period following hot summers than cool summers, a study of 35-year records indicates. The culprit seems to be inadequate dietary intake—as influenced by summer heat—in June, July and August when, the third month from conception, the cerebral cortex of the embryo is becoming organized. Insufficient protein may be particularly dangerous at this time, report Drs. Hilda Knoblock and Benjamin Pasamanick of Ohio State University—*GP,* January, 1958.

Trustees' Meeting: June 15, 1958

At its meeting on June 15, the Board of Trustees took the following actions:

—Appointed Drs. William T. Read of Camden and Felix H. Vann of Englewood as our representatives to the Blood Bank Commission. In addition, Dr. Gardner serves *ex officio*.

—Changed the name of the Special Committee on School Health to Committee on Child Health and expanded its activities to cover the health of children of all ages.

—Voted to support the recommendation of the U. S. Public Health Service to the effect that all persons up to the age of 40 be immunized against poliomyelitis.

—Ordered published in the JOURNAL and in the *News-Letter* the following release from the State Board of Medical Examiners.

Your attention is drawn to the following opinion by the Attorney General as to the legality of bio-analytic technicians and bio-analytic directors other than physicians, taking electrocardiograms:

"There is no authority in the Medical Practice Act which would permit the taking of an electrocardiogram by a laboratory technician or laboratory director, unless the same is performed under the direct supervision of a duly licensed physician and/or surgeon of this State."

Therefore, the taking of electrocardiograms by the above mentioned groups is not legal and this practice must cease at once.

—Approved a report from the Woman's Auxiliary Advisory Committee which listed proposed revisions in the program of our Woman's Auxiliary.

—Heard with approval that the Cumberland County Medical Society had voted a contribution of $1000 to the Albert Barker Kump Memorial Grant.

—Received and filed an acknowledgment of our Society's supplemental grant of $15,000 to the American Medical Education Foundation.

—Voted to send to Senator Case a statement of opposition to the reduction in the appropriation for Medicare. It was felt that this reduction in the Medicare budget "would result in restriction of free choice of physician."

—Voted to send to each member of the House Ways and Means Committee a statement of opposition to HR 9467 (The Forand Bill).

—Invited members of the Mercer County Medical Society to continue to meet in our Medical Society Home on West State Street, indicating that contributions to the support of the building from that society would be welcome.

—Authorized the President and the Chairman of the Board to invite bids from painting contractors for painting the exterior of our building.

—Reaffirmed the Board's action of November 13, 1957 in approving the report of the legislative analyst concerning the statute on examination of hospital records. In this connection, the Board further instructed that a copy of the resolution be sent to the N. J. Hospital Association with a request that its member hospitals be apprised of the desirability of carefully drawing rules and regulations regarding examining of hospital records and adhering to them; and that Middlesex County be informed of the action taken and of the opinion expressed by counsel.

—Approved the list of liaison representatives and special representatives and committees for the Society for 1958-9. (This is published on page 455 of this JOURNAL).

—Adopted the following resolution:

Whereas, the late-lamented Patrick H. Corrigan, M.D., served as a distinguished and faithful member of The Medical Society of New Jersey for more than a quarter of a century, and

Whereas, as member and Secretary of the State Board of Medical Examiners, he rendered long and valuable service to the medical profession and the people of New Jersey, and

Whereas, in his practice he consistently exemplified those qualities of mind and heart which typify the highest standards of professional conduct, therefore be it

Resolved, that the Board of Trustees of The Medical Society of New Jersey record its grief at his passing; and be it further

Resolved, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

—Submitted to the Governor for nomination to the State Board of Medical Exam-

iners the names of Dr. Daniel F. Featherston of Asbury Park, Dr. Edwin H. Albano of Newark and Dr. Joseph M. Keating of Passaic.

—Referred to the Committee on Medical Practice, for study and report a letter from a member in Bridgeton which reported that optometrists are fitting contact lenses in which procedure it is sometimes necessary to instill fluorescein in the eye to detect if there is a correct fit, and if there are any corneal abrasions. He questions the use of drugs by optometrists and suggested the Society employ such measures as are needed to prohibit this practice.

Mr. Backes, counsel, to whom the letter was referred upon receipt, presented a memorandum of his research on the subject. In brief, there is no definite answer in the Medical Practice Act; there is nothing in the act that says only a licensed physician shall use drugs in treatment or diagnosing; the Optometry law allows the employment of objective or subjective means, or both, for the examination of the human eye for the purpose of ascertaining any departure from the normal.

SPECIAL REPRESENTATIVES, COMMITTEE CHAIRMEN AND LIASON REPRESENTATIVES FOR THE MEDICAL SOCIETY OF NEW JERSEY 1958-59

If you do not bind these JOURNALS, cut out these pages and save for reference.

1. Audit Committee
   Dr. Ralph M. L. Buchanan, Phillipsburg

2. Blood Bank Commission of New Jersey
   Dr. William T. Read, Jr., Camden
   Dr. Felix H. Vann, Englewood
   Dr. Kenneth E. Gardner, Ex-Officio, Bloomfield

3. Cardio-Pulmonary Function Laboratory General Advisory Committee
   Dr. Philip J. Kunderman, New Brunswick

4. Civil Defense Organization
   Dr. R. Winfield Betts, Medford

5. Council for Local Public Health Services
   Dr. Ralph M. L. Buchanan, Phillipsburg

6. Crippled Children and Adults, Medical Advisory Committee
   Dr. Henry Briggs, East Orange

7. Crippled Children Commission
   Dr. Frederick G. Dilger, Hackensack

8. Employ the Physically Handicapped, Governor's Committee
   Dr. Kenneth E. Gardner, Bloomfield

9. Epilepsy Project, Society of Crippled Children and Adults
   Dr. Harrison F. English, Trenton

10. Epileptics, Advisory Panel to Motor Vehicle Director
    Dr. Harrison F. English, Trenton

11. Eye Health Screening Program
    Dr. Arthurr E. Sherman, East Orange

12. Fluoridation Joint Committee
    Dr. Charles H. Calvin, Perth Amboy

13. Health Department Liaison with State
    Dr. F. Clyde Bowers, Mendham

14. Health Insurance Conference
    Dr. Daniel F. Featherston, Asbury Park
    Dr. J. Wallace Hurff, Newark
    Dr. Royal A. Schaaf, Califon
    Dr. Marcus H. Greifinger, Newark
    Dr. Rudolph C. Schretzmann, Bergenfield
    Dr. Jesse McCall, Newton
    Dr. Ralph M. L. Buchanan, Phillipsburg
    Mr. Richard I. Nevin, Trenton

15. Historian-Archivist
    Dr. Fred B. Rogers, Trenton

16. Hospital Advisory Council, State Department of Institutions and Agencies
    Dr. C. Byron Blaisdell, Asbury Park
    Dr. Luke A. Mulligan, Leonia

17. Hospital Service Plan Board of Trustees
    Dr. Kenneth E. Gardner, Bloomfield

18. House Maintenance, Staff Policies, and Personnel Relations, Special Committee

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Chairman, Board of Trustees (Dr. Carl N. Ware, Shiloh)

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Secretary (Dr. Marcus H. Greifinger, Newark)

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Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

19. Legislative Keymen, National
Dr. C. Byron Blaisdell, Asbury Park
Dr. Levi M. Walker, Atlantic City (Deputy)

20. Lions Clubs Joint Conference
Dr. Louis S. Wegryn, Elizabeth

21. Medical Care Plans, Stand-by Committee (Institutions and Agencies)
Dr. Charles H. Calvin, Perth Amboy

22. Medical-Legal Testimony, Special Committee
Dr. Marcus H. Greifinger, Newark

23. Medical-Nursing-Hospital Conference
Dr. F. Clyde Bowers, Mendham

24. Medicare Program Special Committee
Dr. Jesse McCall, Newton

25. Mental Health, State Commission on
Dr. Richard E. Gordon, Englewood

26. Nurses' Program on CD-DC
Dr. R. Winfield Betts, Medford

27. Nursing Assistants Special Committee
Dr. Lewis C. Fritts, Somerville

28. Nutrition Council
Dr. S. William Kalb, Newark

29. Pension Plan Special Committee
Dr. David B. Allman, Atlantic City

30. Permanent Committee on Blue Shield and Blue Cross Plans
Dr. Carl N. Ware, Shiloh

31. Public Medical Care, State Commission to Study
Dr. Frank J. Hughes, Camden

32. Safety Council of New Jersey
Mr. R. I. Nevin, Trenton (President's representative)

33. Welfare Council of N. J., Medical Care Committee
Dr. Irving Klompus, Bound Brook

Electrocardiography by Technicians

The following release is from the State Board of Medical Examiners to bio-analytical laboratory directors licensed by that Board.

Your attention is drawn to the following opinion by the Attorney General as to the legality of bio-analytical technicians and bio-analytical directors other than physicians, taking electrocardiograms:

"There is no authority in the Medical Practice Act which would permit the taking of an electrocardiogram by a laboratory technician or laboratory director, unless the same is performed under the direct supervision of a duly licensed physician and/or surgeon of this State."

Therefore, the taking of electrocardiograms by the above mentioned groups is not legal and this practice must cease at once.

Obituaries • • •

DR. CHARLES ENGLANDER

Charles Englander was one of the pioneer neuropsychiatrists of New Jersey. Born in Newark in 1890, he was graduated from the old "Medico-Chi" in 1916. After interning at St. Michael's Hospital in Newark, he served in the Army, and then entered private practice. He eventually became chief of neuropsychiatry at Beth Israel and also at Martland Medical Center. For years he was an Essex County delegate to the state medical society's House of Delegates. A Board diplomate, he was neurologic or psychiatric consultant at a dozen institutions and agencies. His primary service, however, was to the Essex County Overbrook Hospital where he was director of laboratories. He died there of a coronary thrombosis on July 14; he died while dictating the report of an autopsy. He was dictating it into a record, and a play-back discloses his shortness of breath, the struggle to get the words out, and then silence, as the disc turned mutely. For him there was none of the indignity of invalidism nor the helplessness of illness. His last words were, quite literally, uttered in the performance of his duty. He certainly would have wanted to die that way.

DR. FELIX FRISCH

One of central New Jersey's better known psychiatrists and neurologists, Dr. Felix Frisch died on July 5 at his Trenton home. Born in Vienna in 1879, Dr. Frisch was graduated in 1905 from the University there. After a brief period of general practice in Austria he devoted himself increasingly to neurology and psychiatry and in 1940 came to the United States to accept an appointment at the New Jersey Village for Epileptics at Skillman. Later he went into private practice in Trenton. He was the first private practitioner in Mercer County to do electro-encephalography. He was known for his work in neurophysiology and was an expert on the neurologic effects of brain trauma. He became chief of the neurology service at the McKinley Hospital in Trenton and was active in the affairs of the Mercer County Medical Society.

DR. HAROLD HANTMAN

Death came on June 8 to Dr. Harold Hantman, a Newark surgeon. Born in Harrison, N. J. in 1907, Dr. Hantman was graduated in 1931 from the medical school of New York University. After serving an internship at the Martland Medical Center in Newark, he was appointed resident in surgery at the Presbyterian Hospital in that city. He then entered private practice and received places on the surgical staffs of both those hospitals as well as on the staff at Clara Maass Hospital. In fact, he was on his way to do an operation at the latter hospital when he suffered his fatal coronary attack. Dr. Hantman, an FACS, was particularly interested in abdominal and angiological surgery. He was active in the affairs of the Essex County Medical Society and was the holder of an AOA key from Bellevue. Dr. Hantman lived in Newark until 1955 when he moved his residence to Maplewood.

DR. HENRY M. LARSON

One of Morris County's pioneer internists, Dr. Henry Maxwell Larson died on June 6 at the age of 70. Born in Brooklyn in 1888, he received his M.D. degree at Columbia University's College of Physicians and Surgeons in 1914. He then won a fellowship in physiology at the Rockefeller Institute in New York. In 1917 he was commissioned in the medical corps of the Army and served overseas. On his return, he moved to Morristown where he opened his office for private practice. He served the people of that area thereafter for 35 years. He was, for some years, chief of the medical service at Morristown Memorial Hospital. He also was active on the medical service at All Souls' Hospital there, and was for the last few years, a consultant at both hospitals.

Announcements • • •

Obstetrics and Gynecology for GP's

The Woman's Hospital in New York City is offering two courses in obstetrics for general practitioners. Each course is approved for 30 hours category I credit by the American Academy of General Practice. They are given from October 16 to October 30, 1958.

These are full time courses, a week each. Students will work in the clinics. In the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this Graduate instruction will address Mr. Carl P. Wright, Woman's Hospital, 141 West 109th Street, New York 25, New York and an application blank and prospectus will be forwarded.

New N. J. Diplomates in Ob-Gyn

The following New Jersey physicians were certified as diplomates of the American Board of Obstetrics and Gynecology on May 16, 1958:

Adrian, Donald C., Haddonfield
Carll, Jesse W., Bridgeton
Dolan, Jerome A., Jersey City
Federici, Pascal L., Long Branch
Flanagan, James F., Newark
Gaines, John L., Camden
Hahn, Calvin, Vineland
Henry, Francis P., Trenton
Hershey, Sylvan J., Paramus
Landers, David E., Teaneck
Marcellus, Harvey L., Fair Haven
Rose, David J., Princeton
Slowinski, Eugene J., West Orange
Summerson, Donald J., Fort Dix
Van Mater, John S., New Brunswick

Course in Diagnosis of Tuberculosis

In cooperation with the Public Health Service, the Communicable Disease Center, Chamblee, Georgia, will offer a course in Laboratory Methods in the Diagnosis of Tuberculosis on the following dates: October 20-31, 1958; January 26—February 6, 1959.

This is open to all grades of employed laboratory personnel who are approved by their State Health Officers. Practical laboratory training in all phases of tuberculosis bacteriology, including preparation of culture media, microscopy, cultural procedures, diagnostic use of animals, and testing of drug sensitivity will be included in this course. Students who attend this course will be offered a Student Extension Service for a period of 1 year following termination of the course. Laboratory directors and senior laboratory staff members may also make application.

No tuition or laboratory fees are charged. Reservations must be made well in advance.

Application forms may be obtained from the Laboratory Branch, P. O. Box 185, Chamblee, Georgia.

Bibliography on Staphylococci

The National Library of Medicine has compiled a rich bibliography on staphylococcal infection. This is useful to any physician engaged in combatting the increased incidence of antibiotic resistant staphylococcal infection in the home, community and hospital. The bibliography will be sent at no cost on request to the National Library of Medicine at 7th Street and Independence Avenue, s.w., Washington 25, D.C.

New Radiation Manual

For the small sum of 25 cents you can get a new, practical manual on the medical use of x-rays. It covers radiographic technics and the control of radiation hazards. The booklet is a publication of the American College of Radiology and may be obtained by sending 25 cents to that College at 20 North Wacker Drive, Chicago 6, Illinois.

County Society Reports • • •

Bergen

The annual installation meeting of the *Bergen County Medical Society* was called to order by President Fitzpatrick at 7:30 p.m. at Petrullo's Everglades Restaurant, Hackensack, June 10.

President Fitzpatrick welcomed and introduced the following guests: Judge C. Conrad Schneider (Com. Blood Bk.), Mr. Donald G. Borg (Bergen Pines Co. Hosp.), Mr. Arthur A. Kron and Mr. Nelson R. Henson (Engl'd Hosp.), Mr. Martin S. Ulan (Hack. Hosp.), Mr. Mort L. O'Connell (Hasb. Hgts. Hosp.), Dr. Harris K. Cohan (Hasb. Hgts. Hosp.), Dr. Gerard O. Helden (Heart Assn.), Mrs. Tor Richter (Homemakers), Mrs. E. E. Hilbert (N.F.I.P.), Judge Henry J. Bendheim (Bar Assn.), Mr. George Patterson (County CD-DC), Dr. Albert W. Schilke (Dental Soc.), Mr. Albert C. Meyer (Pharm. Assn.), and Mr. T. C. Menzenhauer (Society's Auditor).

The Secretary read the following names, which had been approved by the Executive Committee for election: To Regular from Associate—Mary C. Googe, Rene R. Rohart; To Regular by Transfer—Jerry H. Jacobson, Paul Phillips; To Emeritus—Charles B. Warren; To Associate by Transfer—Francis C. Nichols; To Associate—Ambrose P. Boyle, Robert T. Miller, George C. Peck, Bruce Y. Tapper.

These were all elected to the grades of membership indicated.

The Secretary read the list of new regular members. As each name was read, the doctor was asked to rise and at the conclusion of the reading of the list, President Fitzpatrick welcomed them as permanent members of this Society.

Appreciation was expressed for the long service of Dr. G. B. Barlow to the Bergen County Society

The President requested Dr. William L. Vroom, the oldest living member of the Society, to take a bow. Dr. Vroom was warmly greeted by his colleagues.

The following officers (elected at the Annual Meeting in May to serve for 1958-1959) were asked to come forward as their names were read, to be installed in their respective offices: Alfred A. Alessi — Assistant Treasurer, John P. O'Connor — Treasurer, Charles P. Campbell—Secretary and Reporter, George O. Rowohlt—Second Vice-President, Donald B. Hull—First Vice-President, and George Heller—President.

Dr. Fitzpatrick thanked the previous administration for their conscientious and able assistance during the past year and presented the gavel to Dr. Heller. Dr. Heller accepted the gavel with a brief acknowledgment of the responsibilities of his new office.

Dr. Heller's first official act was to call upon Dr. Winton H. Johnson, Chairman of the Building Committee, for a report on the current status of negotiations for the purchase of a tract of land in Teaneck as a permanent home for the Society. Dr. Johnson reported that the attorney for the Society was in touch with the attorney for the owner and that representations were now being made to the proper authorities in Teaneck, leading to the completion of the contract of sale.

Dr. Heller's second official act was to adjourn the meeting to the buffet dinner at 7:52 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The *Cumberland County Medical Society* was joined by the Woman's Auxiliary as guests of the Owens-Illinois Glass Company for their June 10th meeting at Palatine Lake, with Dr. Paul K. Ayars presiding. There were 49 doctors and their wives present.

Dr. Carl Ware of Shiloh, chairman of the Board of Trustees of the State Medical Society, reported the establishment of the Albert Barker Kump Memorial Grant, in honor of the late Dr. Albert B. Kump, to be supplementary to the Medical Student Loan Fund of The Medical Society of New Jersey. The Cumberland County Society agreed unanimously to contribute to this.

The annual report of the activities of the Auxiliary, submitted by Mrs. Maurice N. Harris, was received with a great deal of interest. A few of the highlights evidenced in this report were: (1) 71 active members, (2) Active participation in the Cancer, Cerebral Palsy, Crippled Kiddies, and Tumor Clinics; in the annual Diabetes Detection Drive; and the Blood Bank, (3) Contributions to the Scholarship Fund for Nurses and the Albert Barker Kump Memorial Grant, and (4) Cited progress on the medical history and bibliography of each Cumberland County physician.

Dr. Richard E. Beck of Millville, chairman of the 1957 Diabetes Detection Drive, gave the final analysis of the diabetic survey. Of 4,000 Drey Paks distributed, there was a 30 per cent return, disclosing fifteen positive (one was a known diabetic, seven were potential diabetics, three were actual diabetics, and four were lost in follow-up procedures).

Dr. Miles Drake of Vineland, reported a new disease entity known as "Tick Paralysis" which was observed in North Carolina and Virginia and which seems to be making its way northward. It produces profound paralysis, ending in death to the patient in 24 to 48 hours.

Treatment is the removal of the tick, which must be done in 6 to 12 hours. The physicians were advised to be on the lookout for this invader.

The committee composed of Drs. Bacon, Ware, and Berkowitz, described a silver tray which was tendered to the family of the late Dr. Kump.

In recognition of his remarkable accomplishments in the county and state societies, a committee was appointed to determine a proper gift for Dr. Carl Ware.

The installation of officers completed the business agenda. The new president, Dr. M. David Baxter of Vineland, introduced his new corps of officers and praised the fine accomplishments of his predecessor, Dr. Paul K. Ayars of Port Norris.

Following the meeting the doctors and their wives were entertained lavishly at a barbecue dinner prepared under the direction of Mr. Herb Hill and his assistants of the Owens-Illinois Glass Company.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

The *Gloucester County Medical Society* met on May 15. The auxiliary members were invited guests.

Dr. Charles S. Cameron, Dean of Hahnemann Medical College, Philadelphia, Pa. was guest speaker. Dr. Cameron is a former Medical Director of the American Cancer Society. His subject was "Review of Smoking: the Cancer Issue." He made clear the definite evidence of the cause and effect relationship of cigarette smoking and cancer of the lung. He appealed to the medical profession to assume responsibility for informing patients, particularly the young, of this relationship.

The Treasurer, Dr. Francis M. Brower, III, reported all dues received and all bills paid.

Dr. Guy Campo, chairman of the Nominating Committee made the following report:

President—Thomas S. Camp, M.D.; Vice-President—Rudolph T. DePersia, M.D.; Secretary—Thomas F. Flynn, Jr., M.D.; Treasurer—Francis M. Brower, III, M.D.; Reporter — Dorothy M. Rogers, M.D.; Historian—George Booth, M.D.; Trustees—Chester I. Ulmer, M.D., 3 years; Earl Wentzell, M.D., 2 years (replacing Dr. Underwood); William T. Beall, M.D., 1 year. Delegates to State Medical Society: Guy Campo, M.D., 3 years; John J. Laurusonis, M.D., 2 years; Louis K. Collins, M.D., 1 year; James G. Kehler, M.D., 1 year. Alternates: William T. Beall, M.D., 3 years; Chester L. Samuelson, M.D., 2 years; Richard H. DuPree, M.D., 1 year; Chester I. Ulmer, M.D., 1 year. All these nominees were elected by unanimous vote.

Members and guests enjoyed a fine collation, wished each other a happy summer time. The one sad event that marred the evening was our learning with shock and sincere sense of loss of the sudden death of Dr. Cecil C. Sheets.

DOROTHY M. ROGERS, M.D.

Reporter

Middlesex

The annual dinner meeting of the *Middlesex County Medical Society* was called to order by Dr. Gerard R. Gessner at the Pines Restaurant, Metuchen, on June 18. One hundred and fifty members, with the wives of members being invited guests, attended the annual dinner meeting. The speaker, Mr. Ashley Montague spoke on *The Natural Superiority of Women.* His talk was well accepted by the women present.

A brief business meeting was conducted, during which the application for two-year Associate membership for Dr. Salvatore Buculo, Perth Amboy, was accepted.

Past-president plaques to 27 past presidents were presented by the retiring president, Dr. Gerard R. Gessner. A similar plaque was presented to Dr. Gessner.

Dr. Joseph Sandella, chairman of the Nominating Committee then presented the slate of officers for 1958-1959 term. These were unanimously accepted as follows:

President— George J. Kohut, M.D.; Vice-President—John A. Smith, M.D.; Secretary—Eugene J. Tyrrell, M.D.; Treasurer—Reuben Levinson, M.D.; Reporter—Donald T. Akey, M.D.

Board of Trustees—Gerard R. Gessner, M.D., Chairman; Sidney D. Becker, M.D., Charles H. Calvin, M.D., Malcolm M. Dunham, M.D., S. David Miller, M.D., Joseph F. Sandella, M.D., William E. Sherman, M.D., Marshall Smith, M.D., Benjamin F. Slobodien, M.D.

Judicial Medical Ethics Committee—B. F. Slobodien, M.D., Chairman, Eugene J. Tyrrell, M.D., J. J. Mann, M.D. (for one year), W. E. Sherman, M.D., S. David Miller, M.D. (for two years).

Delegates and alternates for term of three (3) years: Delegates—F. M. Clarke, M.D., E. F. Klein, M.D., J. A. Smith, M.D., A. Fishkoff, M.D. Alternates—F. S. Taber, M.D., M.B. Jacobson, M.D., Howard Joselson, M.D., Robert C. Steinman, M.D.

Delegates to the 1959 Convention of The Medical Society of New Jersey: Charles H. Calvin, M.D., Alternate—Edward F. Klein, M.D.

Following the election and installation of the 1958-1959 officers, the meeting was adjourned until October 15.

R. G. MATFLERD, M.D.

Reporter

Monmouth

The annual summer outing of the *Monmouth County Medical Society* was held at Deal Golf and Country Club on June 25. Dr. William J. D'Elia, Outing Chairman, was the toastmaster. He was assisted by Doctors James Fisher, Jr. and Morton F. Trippe. The year's activities were summarized by Dr. Theodore Schlossbach, out-going president. He was presented with an engraved gavel in appreciation for his fine work during the past

year. Dr. David McCreight was installed as the incoming president.

Dr. Timothy P. Lee, Rumson, was elected to Active membership. Associate membership was granted to Drs. Herbert Hillemeier, Red Bank, William A. Jamison, Asbury Park, Justin C. Terra, Keyport, and Myra Rose Zinke, Matawan.

The society was honored by the presence of Dr. George Reynolds, this year's recipient of the Golden Merit Award. Dr. Reynolds compared medicine of 50 years ago with that of the present day.

The golf tournament which preceded the dinner meeting saw the following winners: Drs. Joel Feldman, Medical Society Trophy for low gross; Theodore Schlossbach and John Stockfish tied for low net; Howard Pieper, Geriatric Trophy; and Harold Garrity, low gross for guests.

One hundred and thirty members and guests attended the outing which proved to be its usual success.

DONALD W. BOWNE, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

A Short History of Anatomy and Physiology. By Charles Singer. New York, 1958. Dover Publications. Profusely illustrated with many old and rare cuts. ($1.75)

It is sometimes alleged that physicians are less scholarly than they used to be when every doctor could quote Greek and speak Latin. There is some truth to this indictment. In part this descholastization of the practitioner is due to the pressures of the work-a-day world. And, in part, it is due to the decline of interest in medical history. A knowledge of the heritage of your work gives it a new dimension—which is one reason we New Jersey physicians are grateful to this JOURNAL for its series of articles on medical history.

Here is a profusely interesting (and modestly priced) account of the history of physiology and anatomy. From it, I learn that Modrino, in the 14th century, believed that an intestinal wound should be closed by making ants bite on its edges and then cutting off their heads. His descriptions are so vivid that I'm sure that he actually practiced this precept. In spite of his primitive belief, Modrino wrote the first modern work on anatomy in Europe, *Anothomia,* and his anatomic descriptions laid the basis for the discoveries made during the Renaissance.

This book traces the evolution of anatomy from pre-historic times to the 17th century. Using contemporary illustrations, it deals with the discoveries, men, ideas, and misconceptions of these different periods.

Since human dissection was frowned upon during most of this time, anatomists usually worked with animals. This led Aristotle and even Galen into the belief that man's liver had five lobes like a dog's. Vesalius, who drew the human anatomy with revolutionary clarity and accuracy, gave man a five-lobed liver. In other plates in his *De Fabrica* human beings exhibit the larynx of a dog and the ribs of a monkey.

This book makes physiology sound like a detective story.

FELIX UCKO, M.D.

Drugs of Choice 1958-9. Edited by Walter Modell, M.D., St Louis, 1958. Mosby. Pp. 931. ($12.75)

The outpouring of new drugs has placed the practitioner in the midde of a pharmaceutical jungle. To help him hack his way out, several types of manuals have been developed. There are the fine pharmacologic monographs of Beckman, Sollman, and Goodman and Gilman. There are useful little quick reference works like the *Physicians' Desk Reference* and the *Modern Drug Encyclopedia.* And now comes this new volume. The special feature of this work is that it is a book of opinion and not just an almanac of facts. It is prepared by 36 authorities, each covering one or two specialties. Emphasis is on conciseness and practicalness, with some loss of dimension as a result. The author of each section discusses the general problem, points out how the major groups of drugs act, suggests what is lacking in pharmaceutical therapy, and keys the opinions to a bibliographic listing so that the curious or skeptical may run down the references.

In addition to the specific chapters, there is general discussion of pediatric pharmaceutics, diagnostic drugs and principles of drug choice. In the

specific areas, consideration is given to such groups as drugs to combat infection, relieve pain, stimulate medullary centers, maintain homeostasis, dilate peripheral vessels, and so on.

All authors of pharmaceutical treatises are pinned by the problem of proprietary v. generic names. The editor here tries to solve the dilemma by usually (but not invariably) using the generic name in text and the proprietary name in a drug index appended to each chapter. If, for instance, you look for Marsilid® or Adrenalin® in the index you will be referred back simply to a listing. You have to look for iproniazid or epinephrine to be referred to the text material. This is a bit awkward, but there is no perfect way out of the dilemma of generic v. trade names. The fault here is a minor and unavoidable one. The book, as a whole, is a unique and valuable tool for any practitioner of medicine.

Ulysses S. Frank, M.D.

The Neuroses and Their Treatment. Edited by Edward Podolsky, M.D. 1958. New York. The Philosophical Library. Pp. 555. ($10)

With scissors and paste, Dr. Podolsky has assembled 37 articles from various journals, and strung them together like beads. There is no editing, no attempt to relate the articles to each other, to prevent overlapping or to provide synthesis. The papers are long on theory and short on practice. A number of chapters concern drug treatment, but mostly the papers deal with diagnosis and formulation. The book is printed on cheap, coarse paper, poorly bound and outrageously priced at $10. A few of the papers do contain some usable treatment tips, but since the editor neglected to provide an index, these items are lost.

Henry A. Davidson, M.D.

Modern Sex Life. By Edwin W. Hirsch, M.D. Chicago 1958. Research Publications (185 N. Wabash Ave). Signet Books. Pp. 160. Paper. ($0.35)

"Conjugal union" the man says here "all too often consists of a sweat over a live corpse." How to make the body more lively and less corpse-like is the aim of this paper-back, written by a Chicago urologist. He opposes formal psychotherapy, preferring to come at once to the seat of the difficulty. Which, as he sees it, is partly spiritual (self-confidence and so on) and partly physiological or mechanical. Thus he believes that *ejaculatio precox* can be prevented by will power, analogizing it to holding back the urinary stream. And, he writes "there is no danger of the man's organ shrinking if he quietly engages in lulls of spiritual communion."

He is a great believer in will power. "The most trustworthy weapon in the amorous armamentarium is purposeful resolution" he says, in words of more than one syllable. And he believes in physiology too. Thus, "contractibility of the sexual muscles is now known to be a consequence of changes in muscle protein." Also, he believes in poetry. "Poetry," he writes, "is one of the most powerful stimulants to the passive bride. That consenting sigh can often be conjured up by reading some well-turned verses."

All this for only 35 cents! The book closes with some aphorisms, bewilderingly entitled "cardinal principles of psychosomatics." Example: aphorism 8: "Maneuverability is the antidote to amatory monotony."

Victor Huberman, M.D.

A Search for Man's Sanity: The Letters of Trigant Burrow. New York 1958. Oxford University Press. Pp. 616. ($8.75)

Trigant Burrow was one of the most controversial figures in world medicine. It is hard to understand now why his ideas caused such a furor in the 1920s and 1930s. His concept of group therapy, of the unsatisfactory nature of the normal, and of the impossibility of understanding the human being apart from the milieu—all these are the common currency to today's psychiatry. Part of the difficulty which Dr. Burrow experienced in putting over his thesis was, I am sure, due to the complexity of his writing style. In this collection of letters, his writing is lucid and it is easier to see the man through these letters than through his more formal writing. Dr. Burrow was a prodigious correspondent. Here are letters to or from Freud and Jung, Havelock Ellis and Count Korzybski, John Dewey and Walter Cannon. This collection is lovingly compiled by a committee of the Lifwynn Foundation. (Lifwynn is Anglo-Saxon for "joy of life.") This book opens a window into the thinking of a rare genius of our time, a man whose influence is only now beginning to be appreciated.

Abraham Leff, M.D.

The Moon Vow. By Hazel Lin, M.D. New York 1958. Pageant Press. Pp. 312. ($4.00)

Dr. Lin is a member of our Medical Society. This is her second book, and is a word study of one aspect of lesbianism. It is a story of a bride whose marriage has been threatened by a previous homosexual attachment. The hero is a Chinese woman physician who tracks the problem to its source and helps the bride become mature. The book is set in China and the setting is authentic. Dr. Lin is somehow able to maintain scientific objectivity without losing the warmth of human concern.

Herbert Boehm, M.D.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI August, 1958 No. 8

SOME NEW FRONTIERS IN ADULT HEALTH—1956

Jonas N. Muller, M.D., New York State Journal of Medicine, February 15, 1958.

● New knowledge of respiratory infections has made the goal of controlling them a possibility. Community understanding and effort are needed if the prevention of both infectious and noninfectious illnesses is to be effected.

A frontier may be defined as a border between opposites—between the known and the unknown. As the unknown becomes known, new frontiers become apparent. Progress in social and biologic sciences has made it possible for public health to identify some new frontiers.

The fundamental knowledge which made a vaccine against paralytic poliomyelitis possible also makes possible the identification of viruses which play a part in causing acute respiratory infections. This group of infections, usually lumped together under the title of "a cold," is not often considered as a public health problem. But the common respiratory infections are the leading causes of job and school absenteeism, responsible for tremendous losses in productivity; are in each age group the most frequent cause of illness, and are serious obstacles to personal and community well-being.

Not only is the community as a whole directly affected by "colds" but it is clear that achievement of control requires organized community effort. Community support will be required to continue the search for new knowledge and to apply knowledge now available. For example, experimental vaccines against viruses of the respiratory group are being developed and tested with indications of future success. Our understanding and ability to control the serious effects of the many diseases caused by the viruses—measles, mumps, chicken pox, and, more recently, infectious hepatitis—are being advanced likewise.

Our successes in the control of many acute communicable diseases and our increasing concern with noninfectious disease have tended to divert both public and professional attention from other persistent problems of infectious disease. Yet some new frontiers in relation to such old problems might be indicated. There is the need for a new emphasis on common infectious diseases *especially* in the light of a well-justified concern over long-term illness. Current thinking about the causes of chronic disease and disability, and ultimately of death, has begun to theorize about a casual relationship between the so-called minor illnesses, most of them infectious, and the occurrence of long-term illness and final fatal illness. New clues to the control of disease and disability undoubtedly will be found in studies of man's susceptibility to disease.

This chain of thought leads away from infectious disease, but let us return for a moment to one in particular. New knowledge of this disease has brought the realization that the goal of eradication accepted as valid by many in the past may well have been illusory; that a goal of control is still to be achieved. However, control seems more possible for the future than hindsight tells us it might have been in the past—if we can apply the knowledge we already have.

In 1955 this disease killed 15,000 men and women in the United States and an estimated 250,000 were ill with it. In New York City alone there were 1,000 deaths, a total of over 12,000 known cases and an estimated 10,000 persons who did not, and probably do not, know they have this disease. I am speaking of tuberculosis. The dramatic fall in mortality from tuberculosis, beginning in 1947 and greatly accelerating the downward trend already evident, created a false sense of security. The number of newly reported cases has not fallen at the same rate. Adults are still evidencing their infection by the presence of active tuberculosis with tubercle bacilli in their sputum, or by the presence of tuberculosis in

their children. Eighteen of every 1,000 youngsters in a group of pre-school children seen in New York City Child Health Stations in 1955 showed positive skin tests for tuberculosis—evidence, in children, usually not only of recent infection but of an open, active case of tuberculosis in some adult in the child's immediate environment.

This is despite the fact that most patients with tuberculosis can now be rendered noninfectious and that the disease in the patient can be brought under control more readily, since the advent of the antimicrobial drugs. Recent evidence from animal and human experiments suggests that the disease can even be prevented in individuals exposed to a high risk of infection through the prophylactic use of one of these drugs. But the application of these measures of individual treatment and control requires that the presence of the disease be known and that the patient be willing to accept treatment.

We must intensify our efforts to find cases by concentrating on the population groups most likely to harbor tuberculosis. We still have to learn how to reach these groups successfully so that they will make use of the available case-finding services. We also have to learn how to help people accept treatment. Social scientists are working together with other public health people to achieve these ends. Ways are being found to inform and move to action the varied ethnic and cultural groups which make up city populations.

The most difficult group to move to action—at least in terms of one's reasonable expectations—may come as a surprise. Tuberculosis may be found many times more often among people who are entering general hospitals than in the population at large. Therefore, a simple, effective, and economic case-finding device is a routine chest x-ray for all general hospital admissions. As of the beginning of 1956, less than one half of the general hospitals in New York City had instituted such a procedure.

Nevertheless, it is estimated that about one million New Yorkers have their chests x-rayed each year by their own physicians, by union or employer health programs, by health department clinics, by hospitals, and by the mass x-ray survey teams.

The frontier is the effective control of tuberculosis. To reach it, all the knowledge of the past, concerning the relationship between poor housing and overcrowding, malnutrition, and oppresive conditions of work, all concomitants of a low standard of living, and the incidence of tuberculosis, must continue to be applied, together with our newer knowledge concerning the biologic aspects of tuberculosis control.

It is of special interest in talking of the new frontiers of public health as they affect our adult population to recall that tuberculosis was displaced as the leading cause of death in the United States less than fifty years ago, in 1910, when coronary heart disease as we know it today, rose to occupy this position. It has continued to occupy this post of dubious distinction ever since and will probably occupy it for some years to come.

There are many other areas along the frontiers of public health—the prevention of coronary heart disease, the indications for the use of the drugs known as tranquillizers in mental disease, the public health significance of our aging population, may be mentioned as examples. They suggest some of the important adult health responsibilities in our communities. We have helped some people to live longer—we must strive to make that life healthful and satisfying.

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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
ATLANTIC CITY	Bayless Pharmacy, 2000 Atlantic Avenue	ATlantic City 4-2600
BLOOMFIELD	Burgess Chemist, 56 Broad St.	BLoomfield 2-1006
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	EL 6-0150
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Hawthorne Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HOBOKEN	I. Keisman, PhG., 407 First Street	HO 3-9865—4-9606
JERSEY CITY	Owens' Pharmacy, 341 Communipaw Ave.	DElaware 3-6991
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
NEWARK	V. Del Plato, 99 New St.	MArket 2-9094
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
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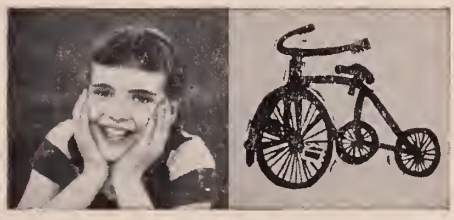
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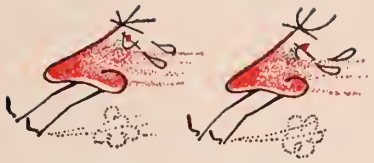
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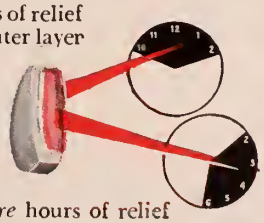
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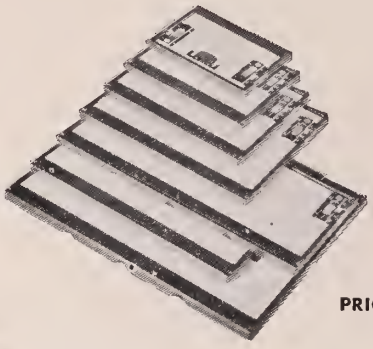
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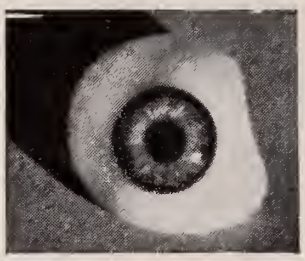
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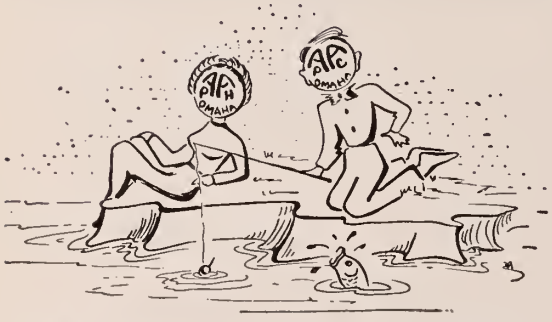
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OF

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WHOLE MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Whole milk	24	480	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

EVAPORATED MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Evaporated milk	11	484	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

An infant will usually take 2 to 3 ounces more than his *age in months* at 3 to 4 hour intervals to satisfy his appetite and nutritional needs. It is psychologically unwise to force prescribed amounts. Normally, the gain in weight of 6 to 8 ounces a week during the earlier months gradually diminishes to 3 to 4 ounces a week by the end of the first year. The standard one-formula mixture not only provides adequate nutrition when vitamin supplements are added; it also provides educational opportunities to prevent feeding problems.

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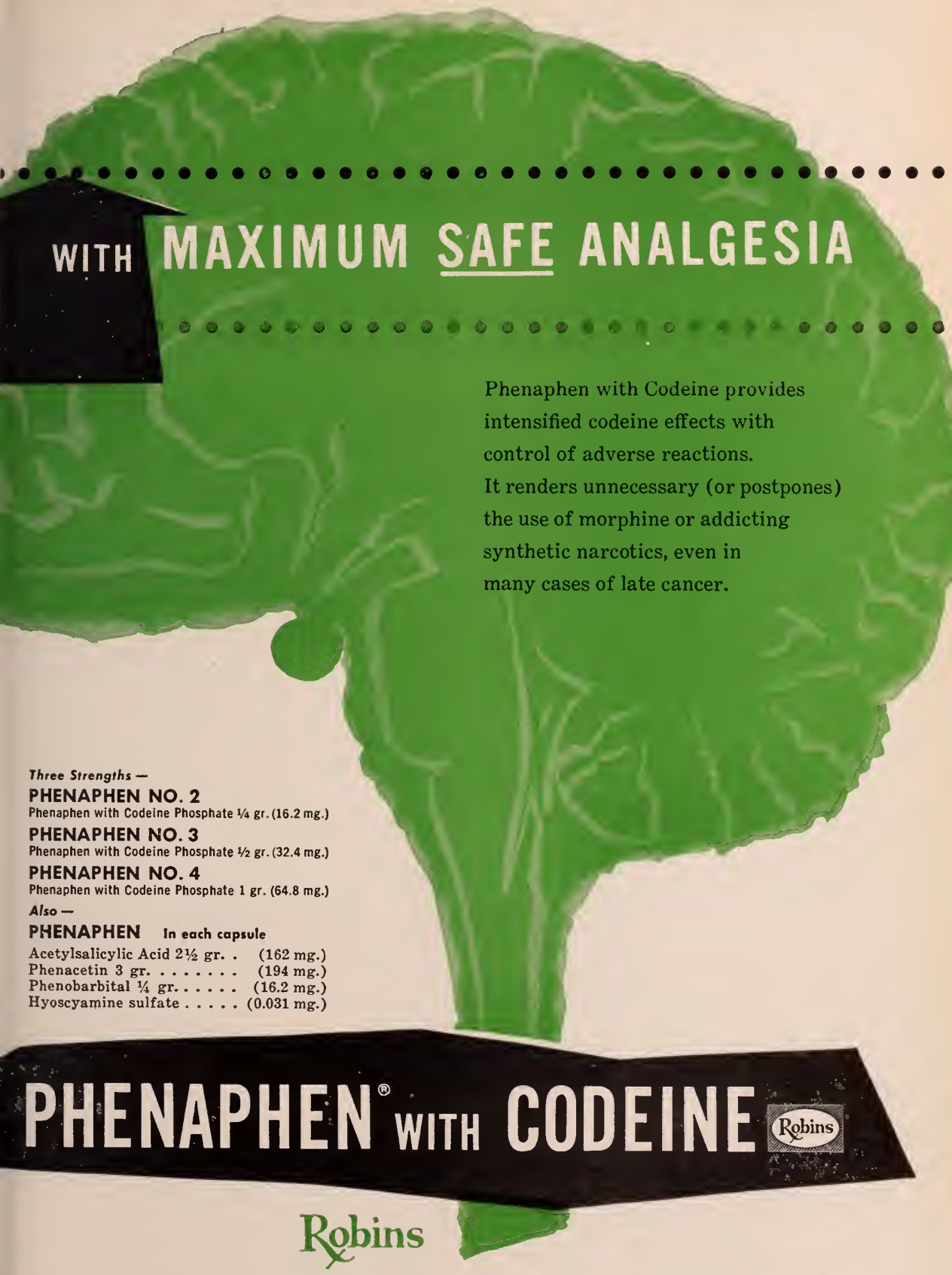
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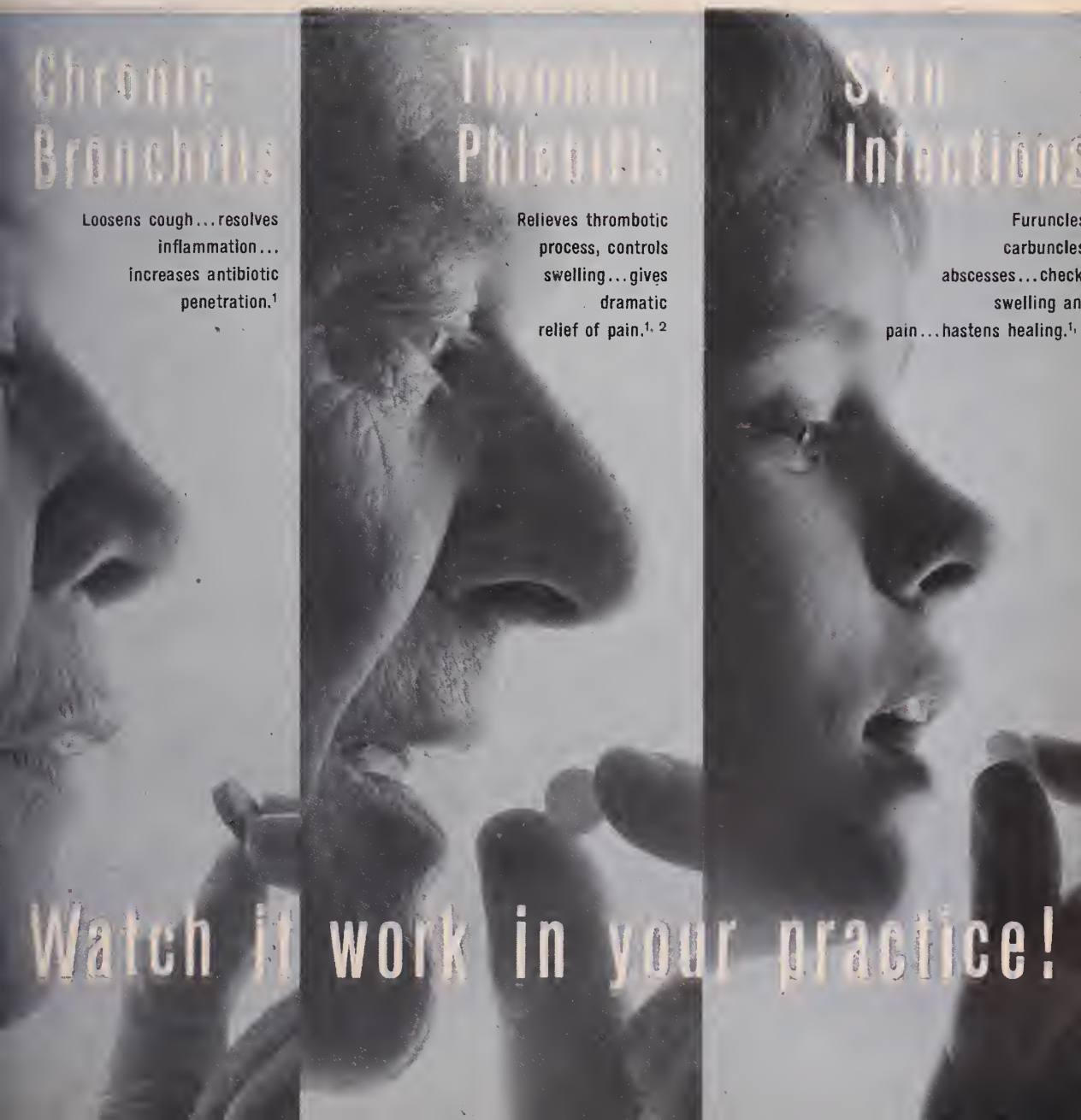
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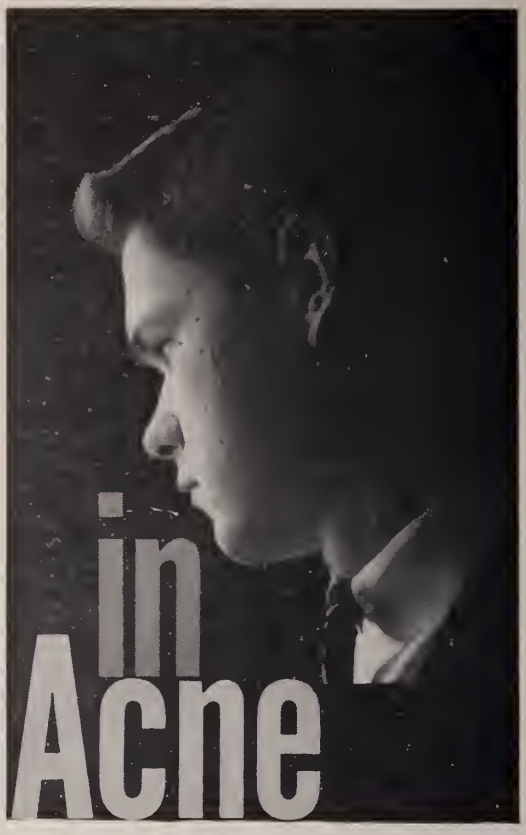
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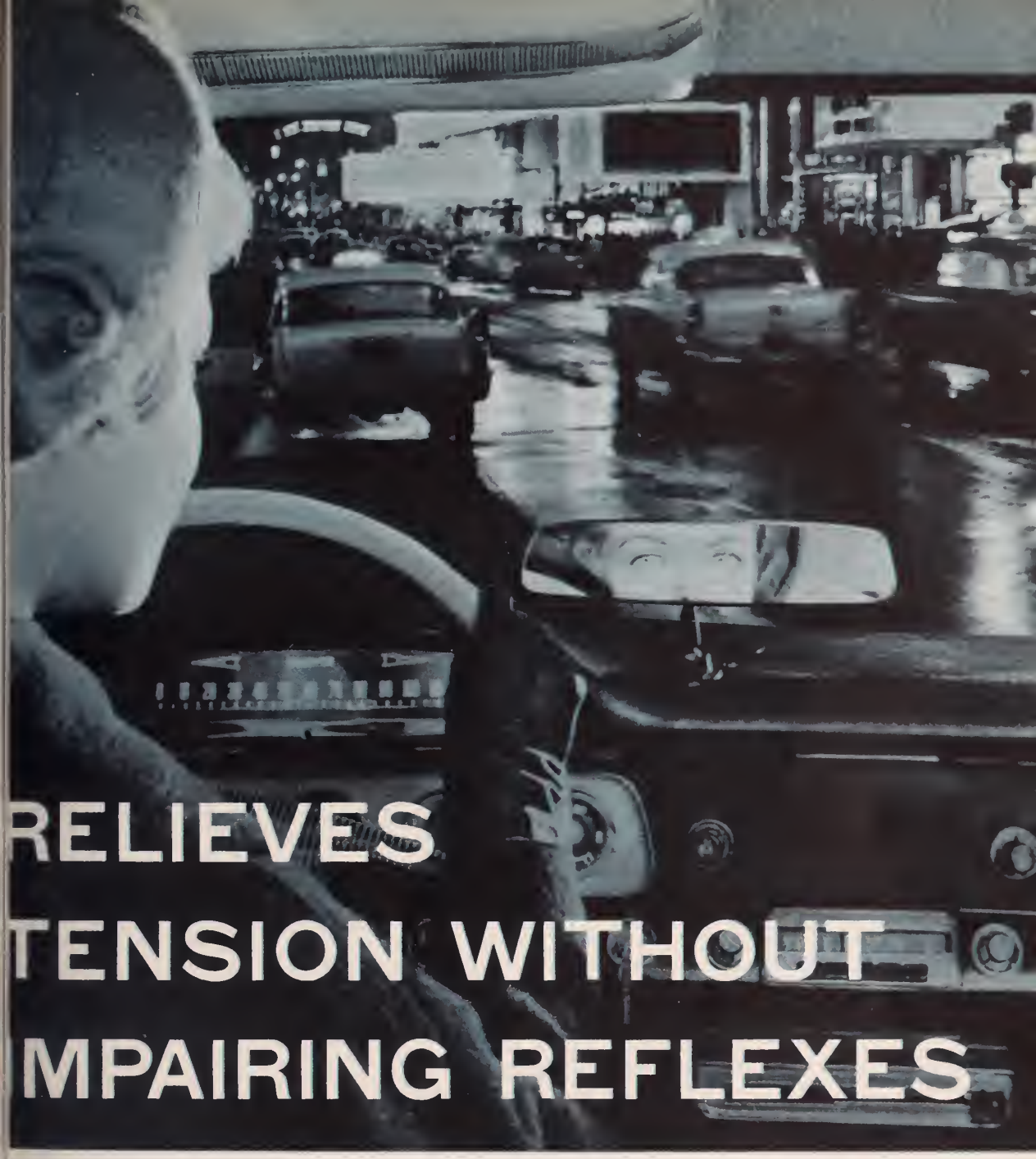
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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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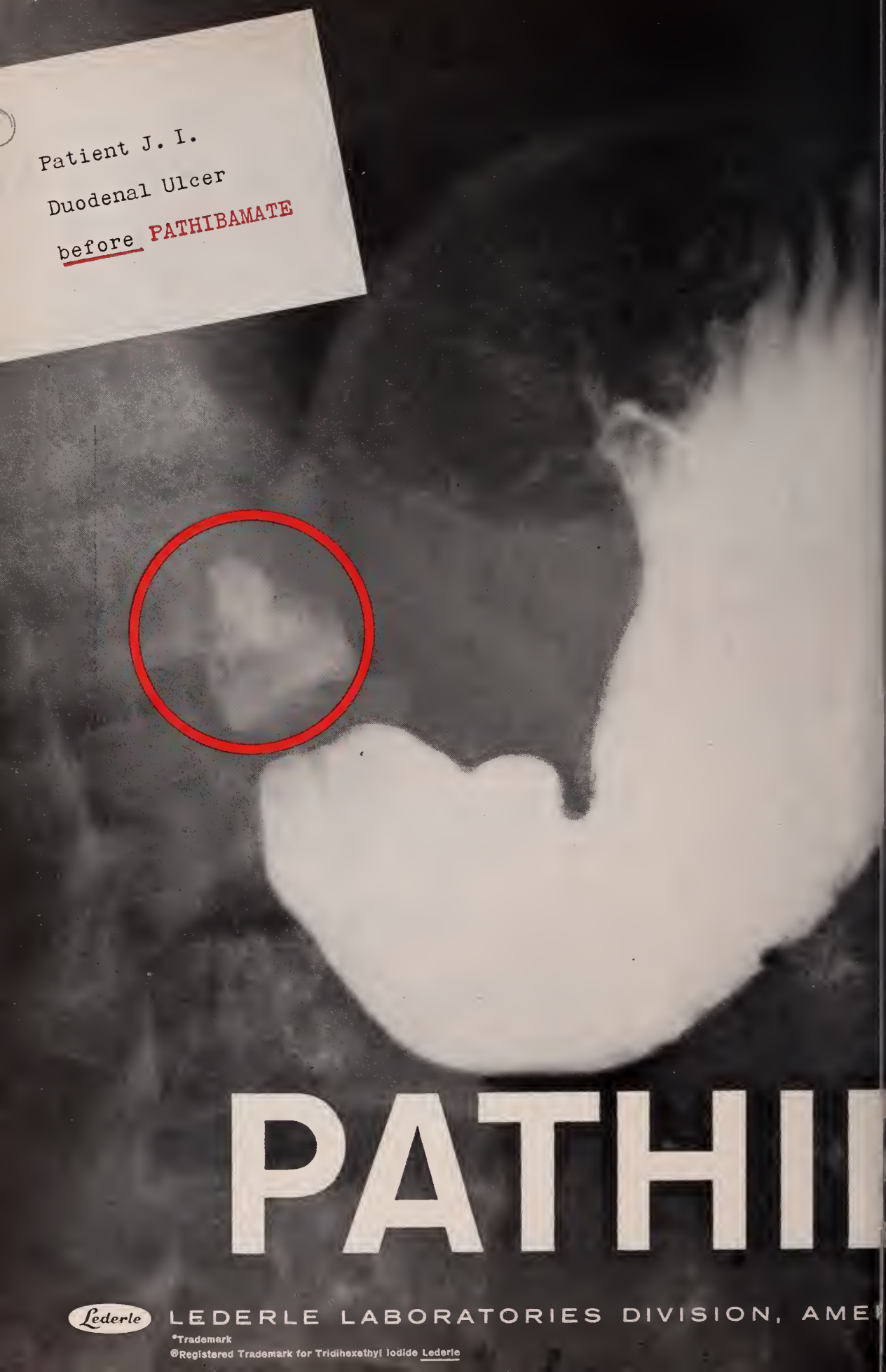
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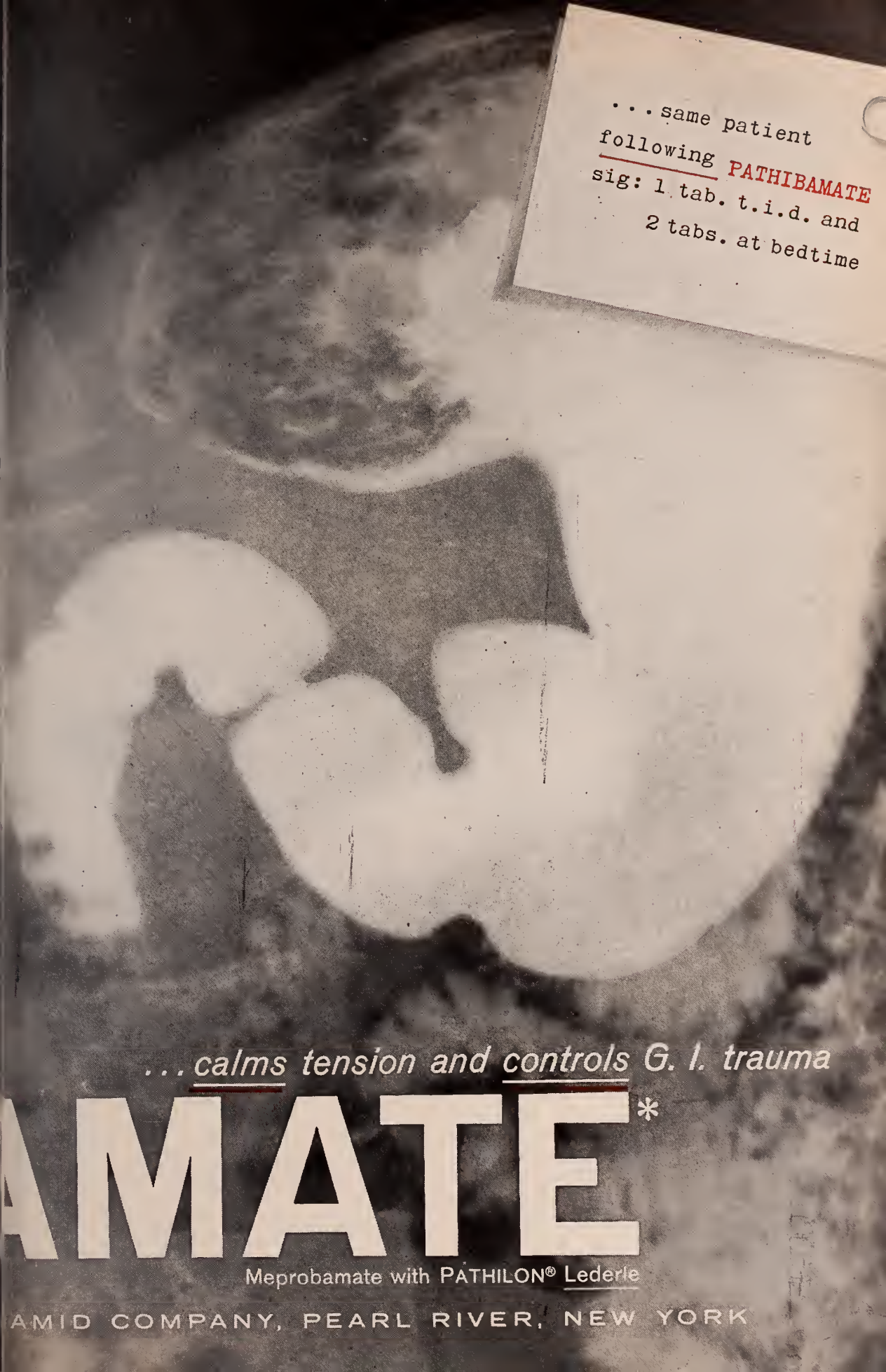
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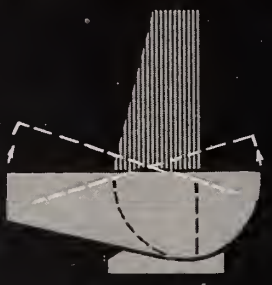
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SUPPLIED:
CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

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Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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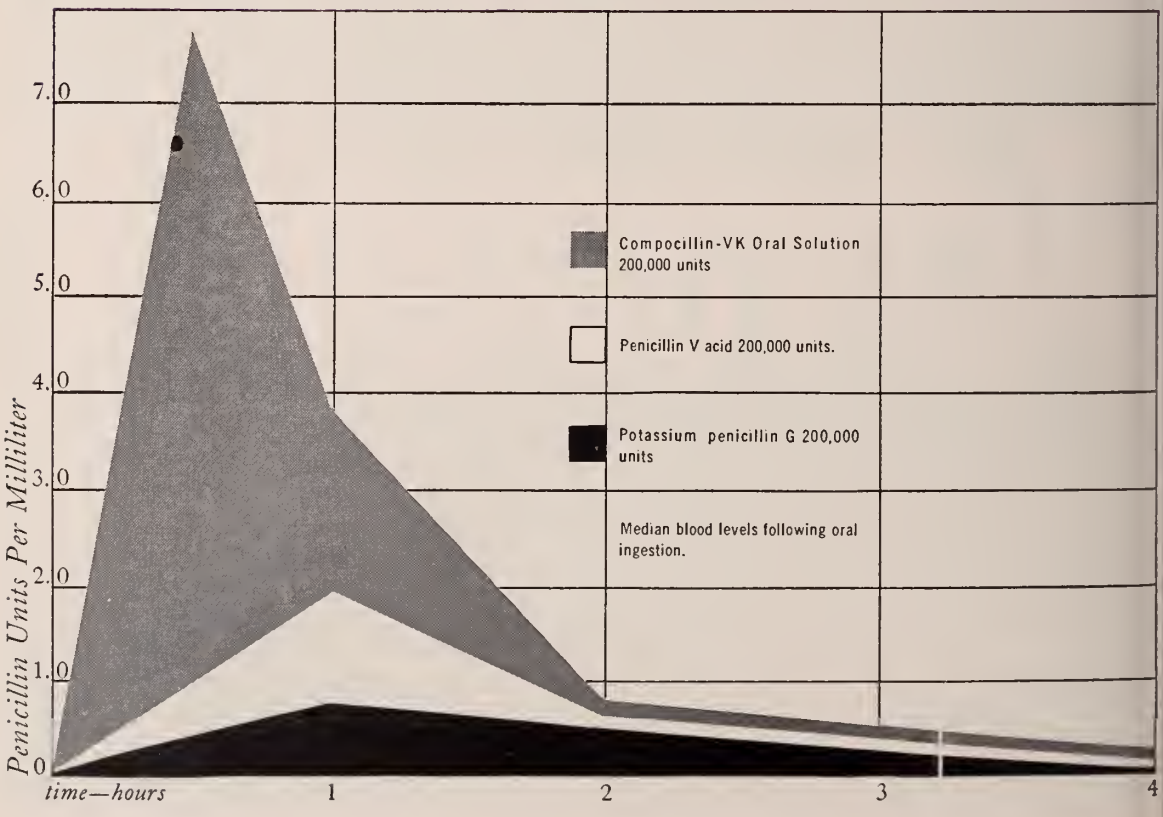
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Source—Lichtenstein, M. E.: GP *16*:114 (Oct.) 1957.

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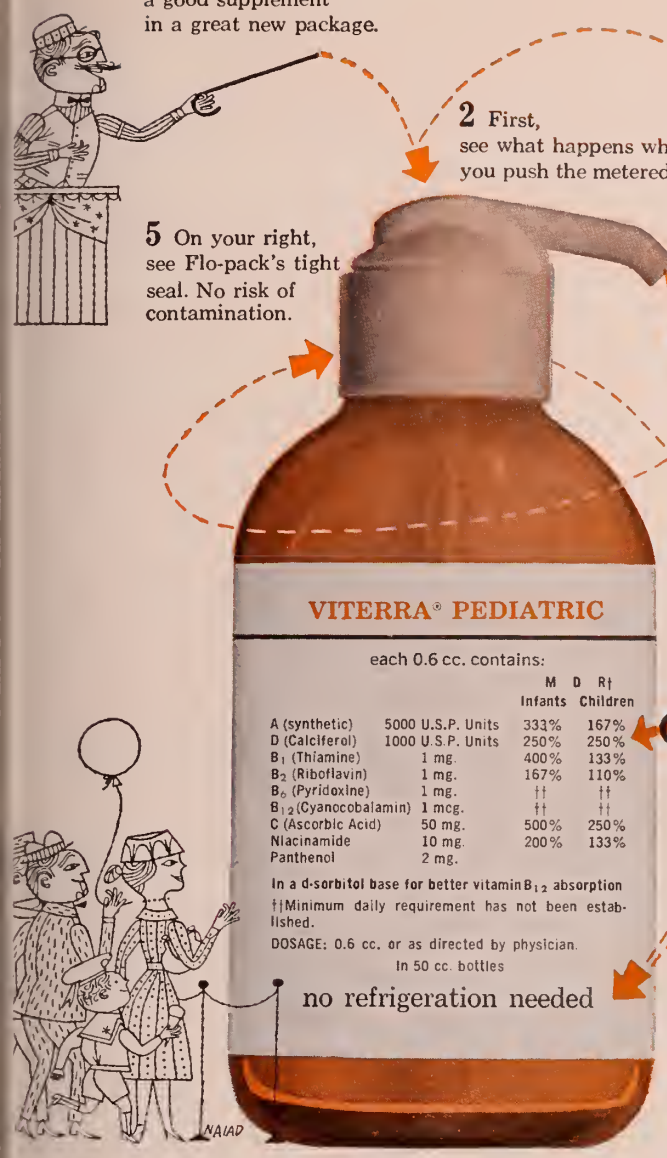
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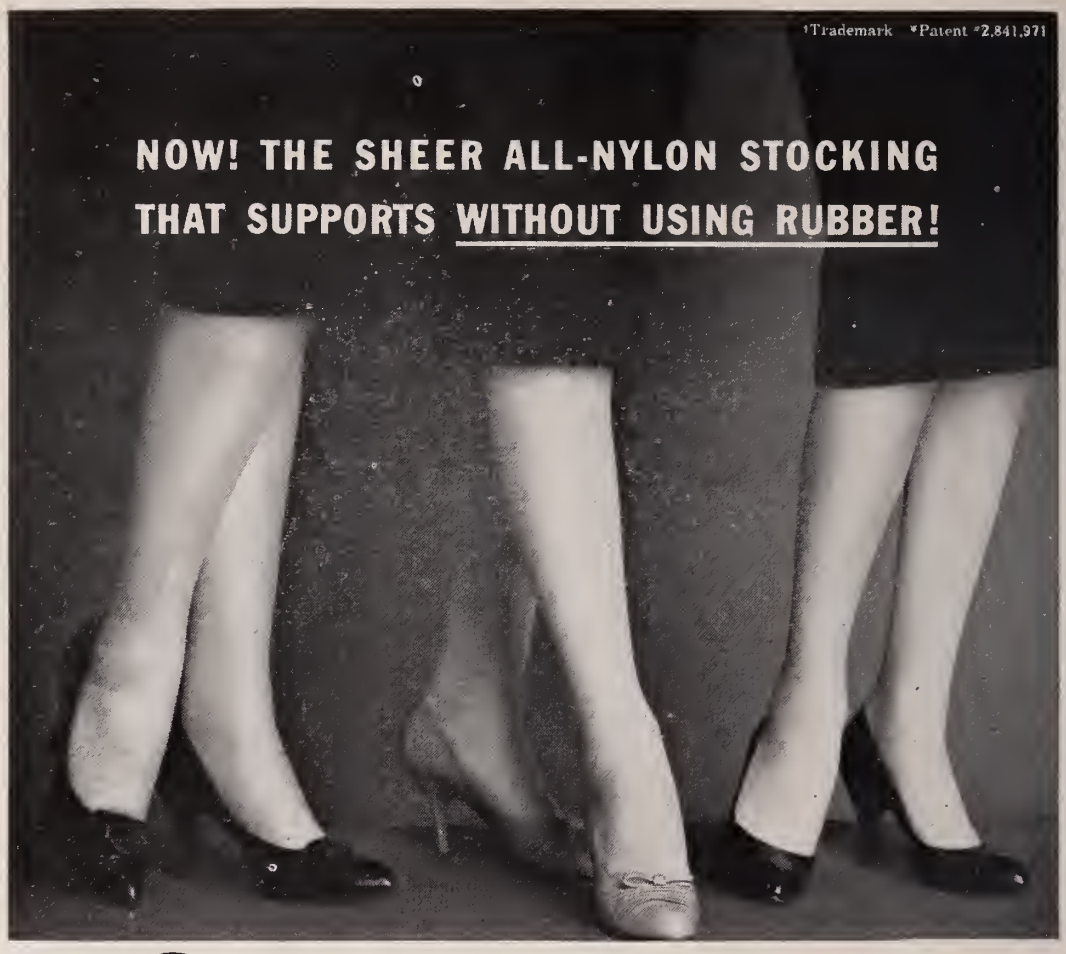
References: 1. Smith, I. M., and Lenyo, L.: Am. Practitioner 9:78, 1958. 2. Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:653, 1955.

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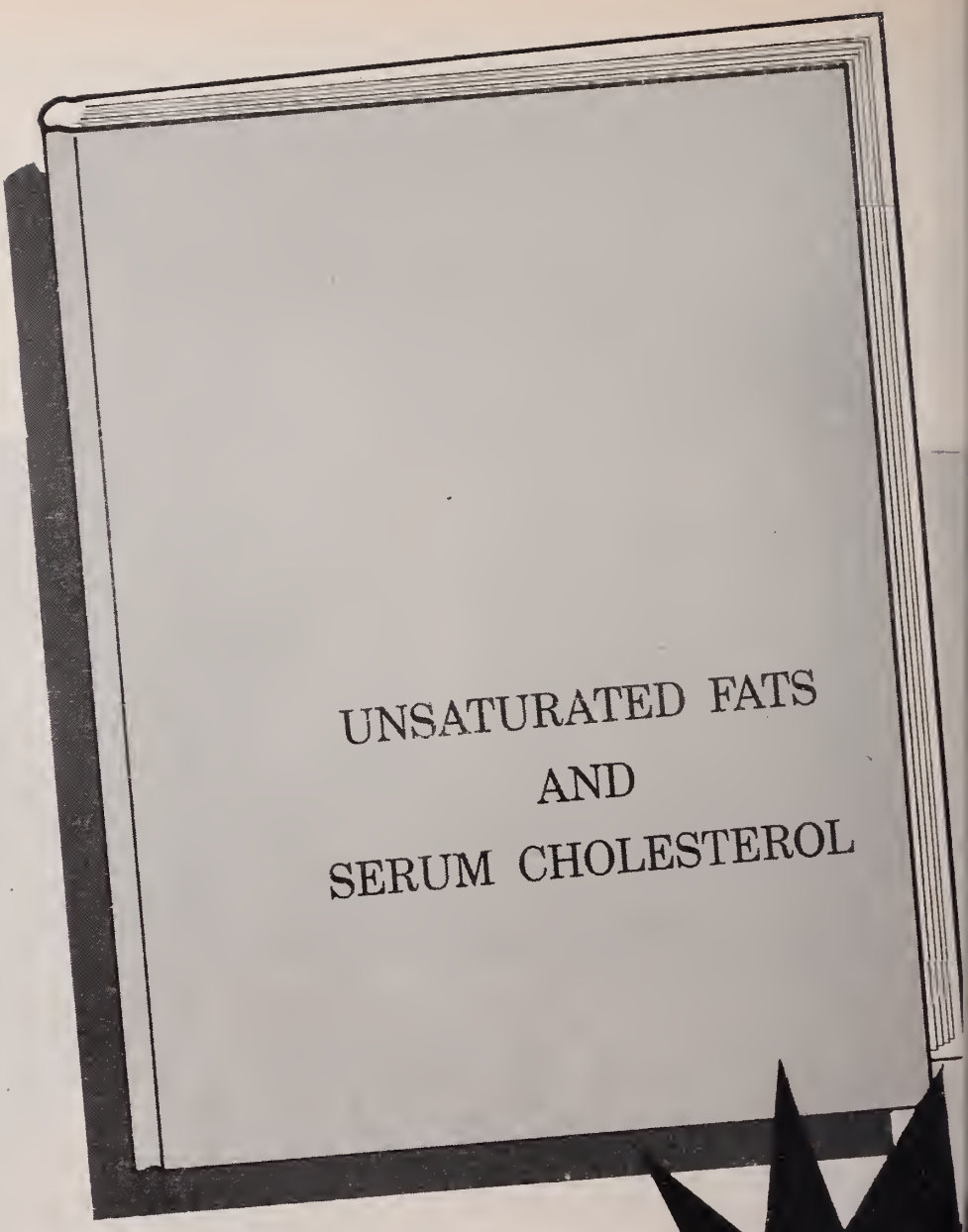
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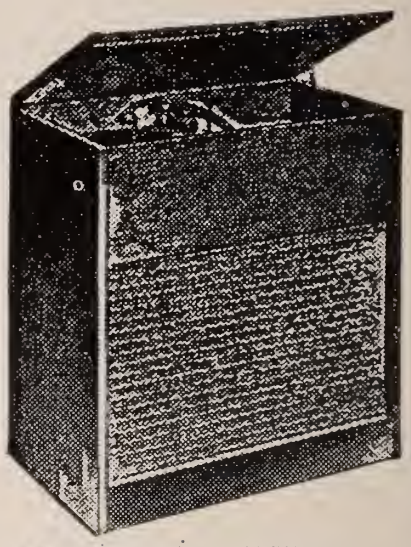
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Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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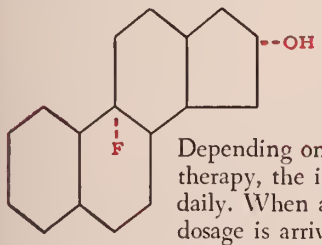
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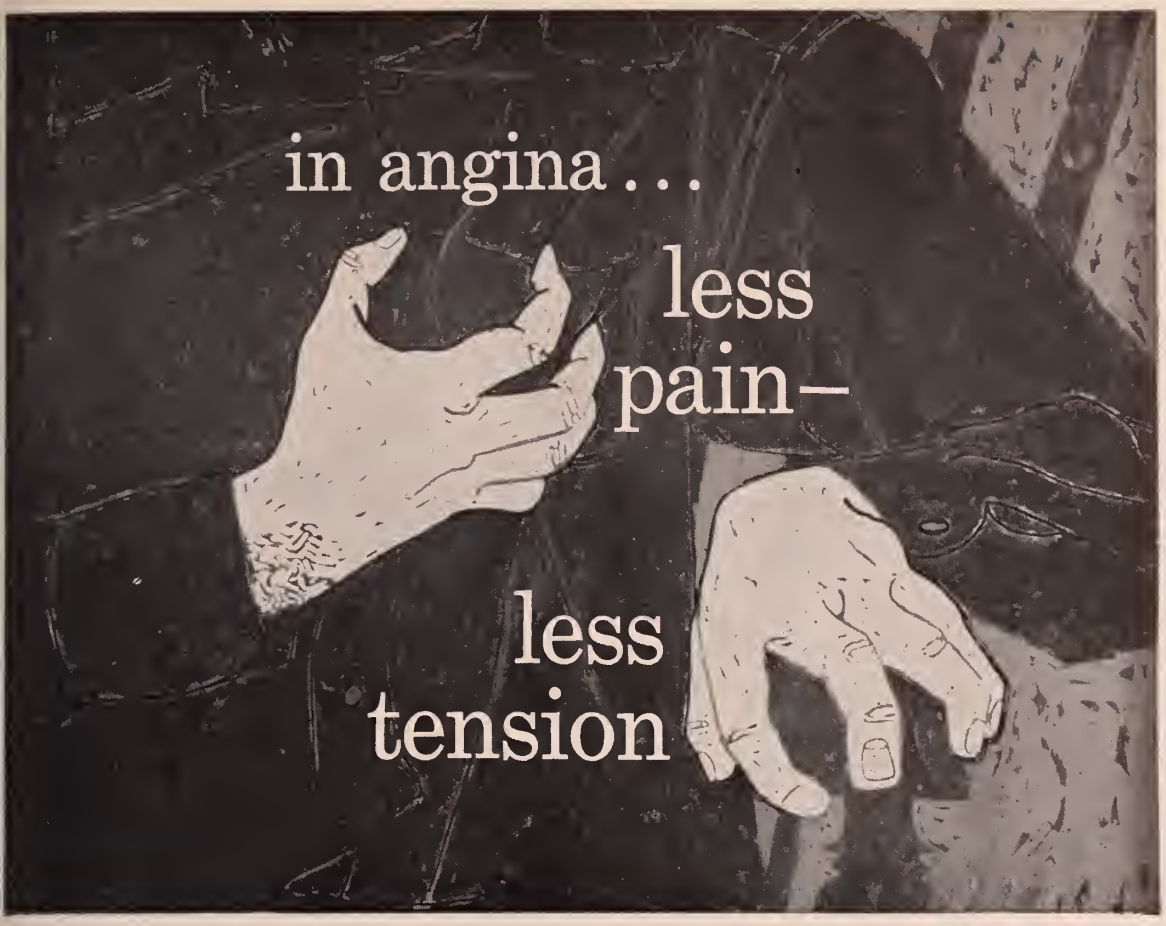
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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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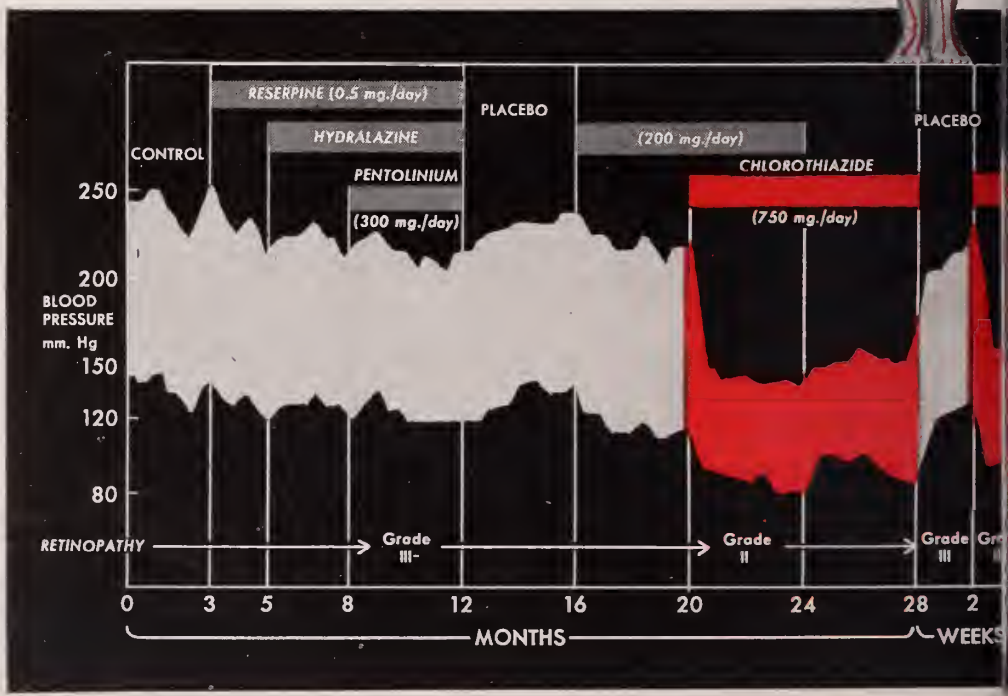
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, Septembe

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1. Thomas, J. W.: Ann. Allergy *16*:128, 1958

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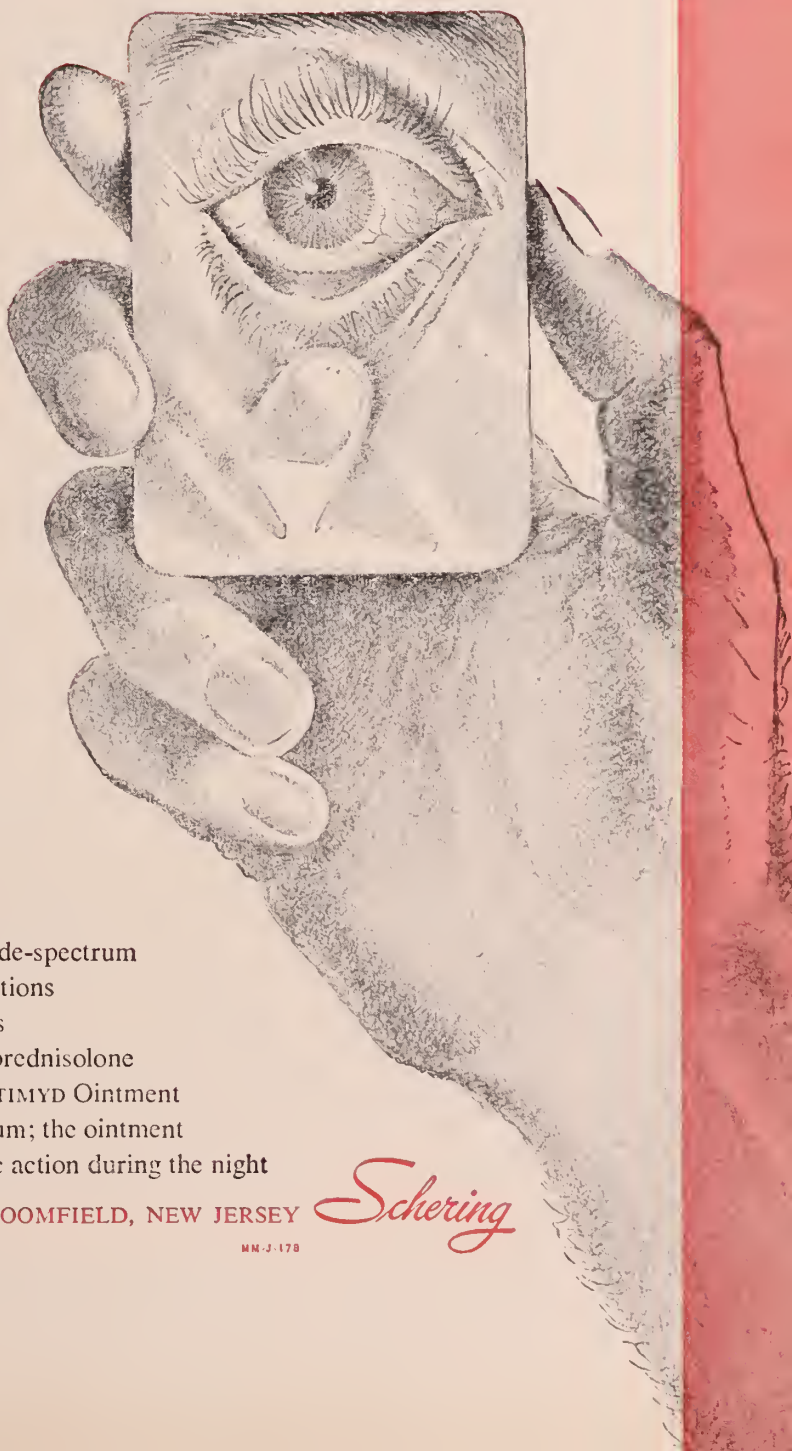
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THE JOURNAL
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Editorials • • •

Diabetes Unconquered

In its monthly statistical bulletin, *Progress in Health Services*, the Health Information Foundation recalled that "forty years ago, a medical diagnosis of diabetes was the equivalent of telling a patient he would soon die."

"Nowadays," HIF continued, "thanks to improved insulin and more recent therapeutic developments, a diabetic who receives proper and continuing treatment can look forward to years of almost-normal life."

Diabetes mortality hit its peak in this century in 1940, when the death rate reached 26 per 100,000 persons. Since then it has declined to 16 per 100,000 population in 1957. Even so, diabetes ranked eighth among the leading causes of death and was responsible for 27,000 deaths last year.

Although diabetes mortality has declined, the incidence of the disease has actually shot up. *There are more known diabetics in New Jersey today than 20 years ago.* In addition to the million Americans known to have diabetes, perhaps a million more are undiscovered victims. And in this state, some 14,000 people alive today will develop diabetes during their lifetime.

Diabetes today is largely a disease of middle and old age. Improvement has been greatest for individuals under 45 years. After insulin was introduced in 1921, the death rate for this age group fell from 5.5 to 3.5 per 100,000 in the space of two years. But for those over 45, diabetes mortality continued to rise until recently. Incidentally, diabetes is the only major cause of death that takes a heavier toll of women than men.

Despite our remarkable success in controlling diabetes, medical science knows little about the disease. Life insurance studies show a link between diabetes deaths and overweight. The psychosomatic experts say that inability to cope successfully with the strains of modern life also plays a role. There is evidence that increasing income and food consumption, sedentary occupations, urbanization and industrialization are implicated.

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The development of improved insulin and a synthetic orally administered compound which lowers blood-sugar levels for some patients are the latest results of our profession's increasing efforts to wipe out diabetes as a cause of death.

Better control of diabetes depends more and more on early detection and treatment. And the first step in that direction is for the American public to become convinced that preventive medicine is an essential requirement for health.

The Psychosomatic Dilemma

Ever hear of the psychosomatic dilemma? Suppose the patient has physical symptoms—say a belly ache—of basically emotional source. Under these circumstances it is wasteful to keep ordering tests: a gastro-intestinal series, a gall-bladder x-ray, a barium enema and so on. Sheer waste. On the other hand, you can't send the patient to the psychiatrist until you have obtained a medical clearance. To do the psychiatric study first is bad because there is no such thing as a negative psychiatric examination. Any psychiatrist can find something wrong with anybody. To do the medical-surgical studies first is extravagant and has the added disadvantage of "fixing" the patient's mind on his body organs when their real aim of treatment is to unfix it. And if you find the first medical study negative (as you will in these cases) then thoroughness demands that you do a second study. There is always one more test you can do if you can't explain the symptom.

The internist or other medical specialist can't trust the psychiatrist with the total care of a peptic ulcer or a mucous colitis. But the psychiatrist won't allow the other doctor to keep prescribing enemata or suppositories for the colitis or pills and powders for the ulcer—because that interferes with psychotherapy.

It is risky to neglect possible physical illness in order to offer psychotherapy. But it is also deleterious—though less obviously so—to concentrate on the physical aspects and neglect the emotional aspects of illness. In fact, to do that is to entrench the psychoneurosis even more deeply.

Nor do you solve the dilemma by having the two doctors work jointly on the same patient. The psychiatrist says that the colitis is due to the emotions—and, he suggests, "let's work this through psychologically without tampering with the physical structure." But the proctologist or gastro-enterologist cannot buy any stock in *that* proposition—so he prescribes the local treatment.

And that's the psychosomatic dilemma. In spades.

Solution, any one?

Who Picks the Label?

When it comes to putting a label on a sickness, who calls the shots? The physician? So you might think. But the patient has his own choice—and he can shape the symptoms to suggest the sickness that he prefers. A complaint like "neuritis in the arm" for instance, is a tip off. The patient does not want arthritis—sounds too crippling. He certainly doesn't want the pain to be due to "nerves" in the colloquial sense of "nerves" being a synonym for "neurosis." He has been frightened at stories of ineffective surgery following "bursitis." But "neuritis"—there's a respectable, hopeful illness—something that's "real" and something of a conversation piece too. So the hopeful offer, "neuritis in the arm, doctor."

One way the patient tries to mould the diagnosis is by suggesting the area of the examination. A complaint of spots before the eyes suggests an ophthalmic study—at least that's

what the patient expects he'll get. So glands in the neck or fullness in the abdomen point the finger at the patient's focus of interest.

If the doctor accepts the patient's label it may be the beginning of a beautiful friendship—though from the clinical viewpoint, not always a constructive one. The physician may *think* that the belly ache is of emotional origin—not even psychosomatic, just psychic. But the patient wants an organic label, and that's how he presents the picture. In our free system, the patient exercises his option by rejecting the doctor who won't buy it on the patient's terms. He wants pills and powders not psychotherapy, and if Dr. A won't give him what he wants, Dr. B will. The doctor gives short shrift to the kinds of patients he dislikes and vice versa. So by a kind of poetic justice, they pair off properly at last. The patient finds the physician who will accept the offered label.

It is, theoretically, possible for the physician to educate the patient away from his desired illness into accepting the truth that he has something else. Usually though if the patient wants to believe that his symptoms are due to overwork, he isn't likely to remain long with the M.D. who pooh poohs that. So here is one of the lost arts of medicine—an art that flourished in the days when "doctor's orders" were obeyed without question or argument. The art of gently persuading the patient to take the doctor's word for it, even if it is an impalatable word.

The Quiet Side of Blue Shield

Scandals get bolder headlines than marriages, births, or philanthropic donations. By the same rule of human perversity, we often take articulate notice of Blue Shield only when we have some fault to find with it.

Whenever four or five colleagues are gathered, some critic may take shots at M-SP. Often the complaint has something to do with the Plan's payments. Perhaps the allowance for a certain procedure seemed inadequate for the particular case, or the Plan didn't cover the diagnostic work that was needed, or the Plan has been persistently requesting a detailed operative report to explain a pending surgical claim.

What's good about Blue Shield, anyway?

Well, for every case where the Plan's payment has been inadequate, delayed, or refused as ineligible—there have been scores of other cases for which reasonable payment has been swiftly remitted. Actually, Blue Shield's payment for an eligible claim, properly presented, is as fast and dependable as any source of income we have on our books.

As for the Blue Shield payment in a particular case, we have a unique recourse. The fee schedule is arrived at—and continually adjusted—with the advice or at the request of our medical society. And if the scheduled payment is out of line with the service required in a particular case, the complainant can ask for a review. Blue Shield is the only prepayment program whose medical policies are subject to our own guidance and control.

Another unique virtue of Blue Shield has to do with the economic segments of the patients whom it covers. Because of its community approach and its unmatched economy of operation, Blue Shield is the one medical prepayment plan that covers the lower income groups who most need protection. Hence, through M-SP, doctors are now being compensated for services rendered to a considerable number of people who, were it not for Blue Shield, would still qualify for our free services in hospital wards and clinics.

Blue Shield is the Profession's Plan, and a successful plan, too. Nationwide, some 43 million patients are now buying Blue Shield every month, and thousands more are joining them every day. In so doing, these friends and neighbors are expressing their confidence in medicine and in our American system of independent private practice.

Blue Shield merits a pat on the back from doctors too.

A. B. Sarewitz, M.D.

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South Orange

Left Heart Catheterization*

New as it is, right heart catheterization is now a solidly established procedure. Catheterization of the left heart is scarcely five years old. The technic, the criteria for case selection and the usefulness of this novel procedure are here discussed and illustrated.

Right heart catheterization has been performed at the Orange Memorial Hospital for the past three years in the study of the hemodynamics of the lesser circulation. It has been of great value in the diagnosis of congenital heart disease, with particular reference to left to right shunts, as well as in the evaluation of acquired heart disease. Here it has helped the identification of lesions of the pulmonic and tricuspid valves and the demonstration of right ventricular myocardial failure and pulmonic hypertension. Right heart catheterization, however, has been of limited value in the study of disease states of the mitral valve and of no help in evaluating those of the aortic valve.

Because surgical correction of some of these left-sided valvular lesions is now feasible, it has become necessary to have an accurate preoperative appraisal of their exact hemodynamics. The technic of left heart catheterization has been developed to fill this need.

The feasibility of performing direct puncture of the left atrium was first demonstrated by Björk[1] in 1953. Since then, two technics have been developed in this country: the transbronchial route and the transthoracic route of Björk as modified by D. L. Fisher.[2] We are greatly indebted to Dr. Fisher in whose laboratory we were permitted to study the method which we are now using.

Indications for left heart catheterization include a systolic murmur at the apex in a patient who has clinical evidence of mitral stenosis. It is important to determine whether this systolic murmur indicates mitral insufficiency, and if so, whether it is of significant degree. Until a satisfactory operation for the relief of mitral insufficiency is developed, patients with this complication are not suitable candidates for mitral commissurotomy. A second indication is an unsatisfactory course in a patient who is doing poorly after mitral commissurotomy. Here the questions of inadequate opening of the valve, restenosis of the valve, left ventricular failure or induced mitral insufficiency are to be answered. Finally, the test is indicated in patients with aortic stenosis, with a view to evaluation and selection for

*From the Cardio-Pulmonary Laboratory of the Hospital Center at Orange, Harvey M. Ewing, M.D., Director.

1. Björk, V. O., Malmstrom, G. and Uggla, L. G.: Annals of Surgery, 138:718 (1953).

2. Fisher, D. L.: Journal of Thoracic Surgery, 30:379 (1955).

aortic valvulotomy. As yet there is no useful technic for the study of aortic insufficiency.

Transthoracic catheterization of the left heart is performed with the patient in the prone position on the fluoroscopy table. A catheter is introduced into the brachial artery and is advanced to the aorta. The center of the heart, which represents the left atrium, is located by brief fluoroscopy. Using procaine infiltration, an 18 gauge, 6 inch, thin wall needle is introduced, through a right paravertebral approach, in the eighth intercostal space. The needle passes to the right of and anterior to the aorta and esophagus, and medial to the right pleural space. At a depth of about ten centimeters a transmitted pulsation is felt, indicating proximity to the heart. The needle is then advanced cautiously, until it perforates the chamber wall. See the figure. The chamber entered is identified by analysis of the oxygen content of the aspirated blood and of the pressure curve. A polyethylene catheter is passed through the needle into the left atrium, and through the mitral valve into the left ventricle. The electrocardiogram, the aortic pressure and the left ventricular pressure are then recorded simultaneously on a multichannel recording device.

From this, the systolic gradient across the aortic valve can be determined and study of the left ventricular pressure curves allows detection of left ventricular failure. Subsequent slow withdrawal of the intracardiac catheter through the mitral valve provides hemodynamic data for the identification of mitral stenosis and mitral insufficiency.

Right heart catheterization can be accomplished during the same procedure where additional information, such as cardiac output or pulmonary artery pressures are desired. This can be done in the conventional method through the brachial vein, or transthoracically by placing a needle in the right atrium in a manner similar to that described above for study of the left heart.

PRIOR to the development of left heart catheterization there was no adequate way of assessing mitral insufficiency complicating mitral stenosis; one such patient, a 36 year old male, was felt to have predominant mitral stenosis, by clinical examination. Because of a soft systolic murmur at the apex he was referred for right heart catheterization. In this test he presented all of the characteristics of mitral stenosis, including an elevation of the pulmonary arterial capillary (wedge) pressure, and elevation of the pulmonary artery pressure. The accepted characteristic of mitral insufficiency, a high V wave coinciding with ventricular systole, was not present in the pressure tracing taken with the catheter in the wedge position. This patient was subsequently subjected to thoracotomy, and at that time a high degree of mitral insufficiency was demonstrated.



In later tests we have subjected similar patients to both right and left heart catheterization and have demonstrated that left ventricular myocardial failure can produce findings in right heart catheterization similar to those changes found in mitral stenosis. Such experiences have reinforced our feeling concerning the value of left heart studies.

Another illustrative case is that of a 46-year old female, who had undergone surgery for mitral stenosis in 1953. Postoperatively she had done rather poorly, with several episodes of congestive heart failure and decreasing exercise tolerance, suggesting either restenosis of the mitral valve or myocardial failure. Left heart catheterization demonstrated a minimal diastolic gradient across the mitral valve with significant mitral insufficiency and left ventricular failure. As a result of this

study the patient was spared a second operation.

The inadequacy of right heart catheterization in clarifying certain diagnostic problems is illustrated by the next case. A 38-year old woman with a history of rheumatic heart disease and mitral stenosis had been in congestive heart failure for two years, and had been fairly well controlled with medical therapy. Examination revealed a diastolic thrill at the apex, with a rumbling diastolic murmur characterized by a presystolic crescendo, and a snapping first mitral sound. These findings strongly suggested mitral stenosis, but there was also a loud systolic murmur, heard best in the pulmonic area, transmitted down the left sternal border to the apex as well as up to the aortic area. The question of an additional defect in the atrial septum or stenosis of the aortic valve was presented. X-ray study and electrocardiography did not clarify the picture. Right heart catheterization failed to demonstrate any evidence of a left to right shunt, but elevation of the right ventricular and pulmonary artery pressures was found. As illustrated in the first case, the elevated pressures in the lesser circulation are nonspecific. Left heart catheterization was performed and the test showed no abnormal pressure gradient across the aortic valve. There was a high ventricular diastolic filling gradient across the mitral valve with a normal left ventricular diastolic pressure and indication of slight mitral insufficiency in the atrial pressure curve. From these studies it was concluded that the patient had a high degree of mitral stenosis, with mild insufficiency, but no evidence of aortic stenosis or left ventricular failure. The confusing systolic murmur was found to be of no significance, and she subsequently underwent a successful mitral commissurotomy. This case illustrates the occasional need for both right and left heart catheterization, each study contributing important information.

A final illustration of the usefulness of left heart catheterization is the case of a 59-year old male with a three-year history of angina pectoris, congestive heart failure and syncopal episodes. In spite of medical therapy his symptoms increased. His blood pressure was normal and there was a rough systolic murmur at the base of the heart. It was felt that if this patient's symptoms were primarily due to significant aortic stenosis, surgical intervention might be of great help. Since this decision depends on knowledge of the gradient across the aortic valve, left heart catheterization was done. Upon testing, it was found that the left ventricular systolic pressure was 110 millimeters of mercury higher than the aortic systolic pressure, indicating a very severe degree of aortic stenosis. The aortic pressure curves also demonstrated the characteristic configuration of aortic stenosis. This patient was subsequently subjected to a transventricular aortic valvulotomy by Dr. Adrian Sabety, at which time these findings were confirmed. An adequate increase in the size of the valve orifice was achieved with a gratifying improvement in the patient's condition.

As can be seen from the foregoing, only those patients have been selected for study for whom possible surgical correction is presently available. One reason for this selectivity is the somewhat increased morbidity of this procedure when compared with right heart catheterization. Although to this date we have had no serious complications, some degree of morbidity is to be expected. General experience indicates that the morbidity is considerably less than that of exploratory cardiotomy.

SUMMARY

THE technic of left heart catheterization by the transthoracic route has been outlined and the nature of the study discussed. The criteria for the selection of cases for study have been enumerated, and the usefulness of the technic in the study of aortic and mitral valvular disease has been illustrated by several cases.

We are indebted to Dr. Mary A. McLaughlin for her valuable professional assistance and to Mr. Massey M. Nakamura for the illustration.

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S. William Kalb, M.D.

Newark

The Management of Obesity*

Dr. Kalb quoted Shakespeare in sending in this paper. "Make less thy body hence and more thy grace. Leave gourmandizing. Know, the grave doth gape for thee thrice wider than other men."

Obesity is not a condition to be left to the charlatan, the beauty salon, or the white-coated television actor. It is a disease of human nutrition, which can cause misery, disability and even death. It is one of America's great health problems and as such is in the jurisdiction of the physician.

Sustained hypertension is found twice as frequently in the obese as in those of normal weight in the same age group. Advanced atherosclerosis was found three times as much in the obese as in those with poor nutrition. Coronary artery disease is much more common in the obese than in persons of normal weight. Abnormalities of the electrocardiograms were found in fifteen per cent of men who were more than twenty-five per cent overweight, as compared with eight and five-tenths per cent in those of normal weight. Anemia was found in seventy-two per cent and gall bladder disease in thirty-seven per cent of these patients. Arthritis and diabetes are also common complications of obesity. The mortality rate among obese individuals is one hundred fifty per cent above the life expectancy.

APPETITE

In appetite, the senses of sight and smell play an important role. A person who develops an increased appetite may eat in spite of the fact that he is not hungry; such as eating a rich dessert after having finished a large dinner. Whether you have contractions of the stomach and are hungry, or whether you are not hungry and just wish to satisfy your appetite does not make any difference. Obesity results from taking advantage of either of these sensations by consuming an increased amount of food. A good hostess is measured on the social scale by the amount of food she can serve. To whet the appetite of her guests makes her a social success.

Many people eat frequently out of sheer habit. They set a definite pattern which is not easy to change, but with determination, can be altered. In some families, this habit has become a tradition. In other people, a lavish table is a symbol of success or a measure of social standing or, habits of overeating are formed in pregnancy or in convalescence following an illness.

CONGENITAL AND PSYCHOLOGIC FACTORS

The way to prevent obesity is to shop around for parents of normal or slender build, six months before you are born. The psychologic factors in obesity begin in early childhood. Eighty-two per cent of obese women had one

*Delivered before the New Jersey branch of the American Pharmaceutical Association at Rutgers University, February 12, 1958.

or both parents who were obese; while only thirty-eight per cent of normal weight patients had similar histories.

It is difficult to determine which is responsible for obesity—heredity or environment. We know that, whichever it is, overeating and inactivity exist, and these must assume the blame for the increase in weight. There are families in which several members are obese. Food has an important place in their family life. If an infant cries he is given a piece of zweibach, bread or a pacifier. He discovers the mouth as an organ of exchange. As he grows to childhood, eating habits are established by the parents. A lolly pop, pretzels, soda, chocolate bars or ice cream on a stick become bargaining agents to keep him quiet. Rather than let "junior" cry or have his way about something, it is easier to keep his mouth occupied and thus keep him quiet. Now frustrations begin! Most of us are frustrated for one reason or another.

I am reminded of a twelve-year old girl who came from a home where both parents were thin. Until she was ten years old, this girl was thin. She weighed fifty pounds. During the two previous summers she was sent to a camp. Here she found that food was plentiful. Watching the other children eat, she began to partake of more and more food. Eating became a lark. It was competitive like the sports in which she participated. At the end of the first summer she had gained sixteen pounds. At home during the year, because of the lean table, she lost eleven pounds. The second summer she took to food "like a duck takes to water," as her mother said, and she gained twenty-two pounds. When she came home this time she demanded more food than the mother was used to serving. She went into tantrums, refused to go to school, played sick so she could stay home and eat more. She continued to gain, and when I saw her she was fifty-eight inches tall and should have weighed eighty-six pounds; instead, she weighed one-hundred thirty-seven pounds. This was not a case of heredity, but one of environment.

In another case, the father and daughter were slim; the mother and son were obese. The father had financial difficulties and plunged into a severe depressive reaction. The daughter was depressed at seeing her father so ill. The father and daughter, already slim, lost more weight. The whole picture upset the mother and son, and they too became tense and anxious. They showed their anxiety by a kind of "nervous" eating, so the fat ones became fatter and the thin ones thinner. Then the father recovered from his depression (he had electric shock therapy) and regained his appetite. His weight went up. This cheered the daughter so her weight went up. This relieved the other two of the need for this "nervous" eating, so their weight went down. Thus, heredity, environment and stress all played a part in this family drama.

Obese individuals carry genetic factors influencing obesity. They may carry genes for slenderness as well; hence we may find a lean member in a family of excessive obesity. Lean people very rarely carry genes for obesity. Variations in body build, such as a normal body with very heavy thighs, may come from the genes of one parent.

In my own series of eight thousand obese patients, 72 per cent had at least one obese parent, while in 23 per cent both parents were obese. Certain types of diets are predominant in various racial and religious groups. The Italians favor an abundance of starches, oils, and spices. The Jews like to supplement their diet with fatty foods, sweets, and fruits. The Poles, with pork products and sweets. And so it is with various groups that are prone to influences of climate and national origin.

The question remains as to whether there are independent genes for obesity and leanness which are transmitted alone, or whether they exist in conjunction with genes of endocrine glands and which ones, or with genes of the nervous system or some other genetic independent causative factors.

Emotional problems are common in obese individuals. Such disorders may cause not only neuroses, but behavior problems that result in self-inflicted misery. These may also develop when the patient is placed on a strict dietary regime. Eating is an outlet for frustrations and anxieties. Eating is a crutch for some people when they develop problems. I have referred many obese patients to psychiatrists because of this. Some of them have become emotionally stable as a result of psychiatric care. Most of them were still obese.

Endocrine factors play a small role, though at one time or another every ductless gland in the body was blamed for obesity. Even today many weight-reducing preparations contain thyroid extract. To prescribe thyroid-containing drugs without a careful endocrine evaluation is to invite thyrotoxicosis and even to

aggravate a possible, underlying, unrecognized cardiac disorder.

TREATMENT OF OBESITY

THE success of therapy may turn on the patient's reason for coming to the doctor. If a patient presents himself because someone else has urged him to do so, the reducing regime will not be very satisfactory. On the other hand, if he comes of his own volition, results are usually successful. If there is an underlying pathologic reason, such as heart disease, hypertension, diabetes, gall bladder disease, arthritis, or if a patient needs an operation and is told he is a poor surgical risk, or if a female patient cannot become pregnant because of hormonal imbalance as a result of overweight, then the reducing regime takes on a serious atmosphere and adherence to a diet becomes an accomplishment. During the war, many young men came to the office to reduce weight because they wanted to get a commission in the service. Their obesity was a hindrance and they had a definite goal to reach in order to insure a better rating. These were all successful reducers.

Drugs are devices to get a patient to adhere to a diet. They impress the patient with adjunctive therapy to the diet. The doctor himself must find worthwhile drugs, and he must impart his enthusiasm to his patient. The patient's response will be in proportion to the doctor's interest. Without such a device it may be difficult to maintain the patient on the diet. Visible frustration or disappointment in a doctor is sensed by the patient. They should not get involved emotionally. It is important that the patient be seen at *regular intervals* to bolster his morale and to check on his medication. Many technics must be devised to keep the patient interested. To give thyroid to a patient who has an increased metabolism or an increased radioactive uptake may be dangerous. Many people have developed goiters and depressions by taking this drug unnecessarily. To lose weight with thyroid, it must be given in toxic doses. The only reason is to keep the metabolism near normal, because there is a tendency for the basal metabolic rate to drop when a patient loses weight.

Amphetamine or any related drug should be prescribed cautiously. I have seen amphetamine "cripples" by prolonged use of this drug. Amphetamine or related substances do not inhibit the appetite or allay hunger, except in a small group of patients for a limited time. People who take this drug sometimes act like cocaine addicts. They are "hopped-up," have insomnia, halitosis, dryness of the mouth, nose, and vagina. They develop cramps in the legs. They walk around with headaches, and get blurring of vision. Many automobile accidents can be attributed to this drug.

APPETITE-CURBING drugs may aid the patient to get over the "hump" of adhering to a strict diet by giving them a feeling of well being. However, the substance must be one that will not aggravate any existing emotional or psychic condition. Insomnia, which is so common a complaint, after use of central nervous system stimulants, must be avoided. Normal sleep should not be interfered with by diet supplements. Reliance on drugs alone, whether they be anorexogenic, tranquilizers or sedatives, can be a serious blunder.

Di nitro phenol is not easy to find in a drug store, but it is still used. It causes weight loss by its toxic action. It is a powerful metabolic stimulant. It may cause yellow atrophy of the liver, nephritis, cataracts, neuritis, and skin rashes.

Belladonna is found in many reducing preparations. It acts by diminishing gastric motility, and hence diminishes the appetite to some degree. However, it must be used in large doses to accomplish an anhedonic effect, and large doses may cause serious side effects.

Bulk-producing laxatives are found in many formulae. Methylcellulose is a carbohydrate which stimulates peristalsis and aids intestinal elimination. It is not assimilated by the body, but contributes to bulk, not in the stomach, but in the large bowel, where no sense of fullness is felt. It is contraindicated in adhesions of the intestines. It produces narrowing of the

lumen of the intestinal tract, causing pain. It may also cause vomiting. In ulcerated colitis it causes excessive spasm, thereby producing increased irritation. It may contribute to esophageal impaction and intestinal obstruction.

Ammonium chloride is used for water elimination. It may cause severe acidosis. Purging will derange bowel habits, and irritate the bowel to bring about an irritative ulcerative colitis. Fatalities have followed the use of this drug. Loss of weight is caused by eliminating water from the bowels. This is temporary, and the body remains in fluid equilibrium. Any fluid retention in excess of twelve to fifteen pounds results in edema. The average obese person *per se* is not edematous. In treating the obese, it is desirable that fat be eliminated, not water; when excessive fat is removed, the fluid which was retained in it is also eliminated. The elimination of fluid without fat results in the rapid accumulation of fluid. Mercurial or similar injections are irritative diuretics. They produce a temporary loss in fluid which is replaced by the ingestion of liquids.

VITAMINS and minerals do not cause weight loss. They may be used as a supplement to a low-calorie diet where deficiencies of one or more of these exist. In addition to any other etiologic factor, there does exist some degree of malnutrition in obesity. To help alleviate some mineral or vitamin deficiency, it is essential that a preparation be given that contains important ingredients in maximum doses, and not a capsule or liquid of "names" in minimal doses, as is so often recommended. Vitamin C is the active ingredient of several reducing preparations. It is true that this has been used to eliminate fluid in congestive heart failure, but every obese person does not have congestive heart failure. To promote diuresis, it is necessary to give about two or three Grams of vitamin C a day. The reducing preparations which have this ingredient contain only a minimal amount per dose. Besides, we are concerned with removing fat from the tissues, and not fluids.

Since 72 per cent of obese individuals have some form of secondary anemia, it is advisable that liver, iron, and/or B_{12} be given.

Surgical removal of fat pads from the body is occasionally performed in patients who have lost one hundred or more pounds. The overhanging skin, such as an abdominal apron, excess or redundant skin over the upper arms or thighs, or pendulous breasts may be reasons for a plastic operation after dietotherapy has been completed. To operate on an obese individual for removal of fat may create a hazard. There is a risk of fat embolism occurring and of delayed tissue repair. This does not produce the desired result, since fat may accumulate again in the same places following weight gain without adequate dietary supervision.

I am reminded of a case appearing in the literature. This patient had a third degree burn of the hand. It was necessary to do a skin graft. The surgeon grafted part of the skin from the abdomen to the dorsum of the hand. This was done at a time when the patient had been dieting and had lost considerable weight. After several months the patient started to gain weight. The grafted portion on the hand began to accumulate a large fat pad at the same time that the abdomen became obese. Some time later, the patient went back on a diet and as she lost in measurements around the abdomen, she also lost the fat pad from the dorsum of the hand.

Diet therapy is the only way to get a satisfactory loss of weight. Since it is impractical for most people to follow a regime of exercise or energy expenditure, it becomes necessary then, to follow a scheme by which reduction in calories or restriction of food intake is possible. This is the only factor in securing weight loss with a minimal effort and the greatest amount of safety. Patients who adhere to a low-calorie diet inevitably lose weight. This is true whether or not they take supplementary medication.

The doctor must determine the amount of weight a patient should lose to keep him in caloric balance. Once his normal weight is maintained for six months to a year, the chances are that the patient will keep his weight down for a long time. Chemical changes will occur in the liver, intestines, and other tissues which will put the patient in chemical balance to accommodate the reduced weight.

A diet must be fitted to the patient like a suit of clothes. A thirty-eight short suit won't fit a six foot, two-hundred pound man any more than a forty-two long suit would fit a five-foot-five-inch, one-hundred sixty pound man.

To calculate a diet you have to know the height, weight, occupation, surface area, the calories per hour that are used; the heat production of the body, and what underlying pathology exists. Suppose a patient had an undiscovered diabetes, or gastric ulcer, or arthritis, or anemia, or heart condition. Do you think a common diet would be advisable for all these conditions?

The amount of the essential elements such as protein, carbohydrate and fat must be adjusted to the needs of the patient. A diet of sixty per cent protein, twenty-five per cent carbohydrate and fifteen per cent fat may be a good reducing diet for one patient, while a diet of fifty per cent protein, thirty per cent carbohydrate, and twenty per cent fat may be better for another. The minimum amount of protein in a reducing diet that will keep the patient in nitrogen equilibrium depends on the amount of carbohydrate prescribed. The minimum of carbohydrate contained in the diet to prevent ketosis depends on the amount of protein that is being metabolized and on the amount of fat that is utilized.

The anatomic and functional structure of the body weight regulatory mechanism should be compared with hemostatic blood sugar regulation to accomplish better weight reduction. Only by having this information can you determine the ability of the liver to remove glucose from the blood stream when the blood sugar tends to rise, and releases glucose into the blood stream when the blood sugar level tends to fall. We must also determine the ability of fat depots to store and release fat. Consideration should be given to both mechanisms, since they may be inherited or acquired. The patient should be studied, and then the proper diet prescribed for his particular needs. The degree of weight loss should not be rapid, but rather leisurely—about two pounds a week.

CONTRAINDICATIONS TO WEIGHT REDUCTION

YOUNG children and people over age seventy do not tolerate sub-caloric intake. In children, new eating habits should be instituted by education. In the aged, the remaining years should not be taxed with rigid dieting.

Active tuberculosis, while not common in the obese, is a contraindication. The patient may develop malnutrition, which may make treatment more difficult.

Cirrhosis of the liver is a disease which demands an increased amount of carbohydrate and protein. This type of patient is on the losing end as a result of the cirrhosis.

Addison's disease results from the impaired function of the adrenal cortex. The changes lead to an upset in the mineral and water balance. The symptoms in themselves usually help to produce loss of weight; hence, the obese patient with this condition should be left alone.

Patients with active gastric or duodenal ulcer or chronic ulcerative colitis should be placed on diets low in purines and high in calories. These conditions do not lend themselves to a reduction diet.

Inoperable cancer, or advanced stages of malignancy should not make one too concerned about reducing. They will lose weight soon enough as a result of the wasting which is due to follow.

Any cachectic or chronically ill patient should be left alone, unless the obesity is extreme. Then they should be advised to limit the intake of food slowly.

MASSAGE AND EXERCISE

MILLIONS of dollars each year are swindled from the public by beauty salons, health clubs, gymnasiums, turkish baths, and health farms. Misleading claims are made regarding massage, baths and exercise. Massage is a fallacy in weight reduction. Whether it be a hand massage, vibrating machine, a bed with rollers, or electric pads makes little difference. Fat is not mobilized into the blood stream from its original depots by these methods or by gadgets.

A number of years ago, I undertook a study to determine the value of massage as a therapeutic aid in the treatment of obesity. This was done in the Nutrition and Physical Therapy Clinics of the New York Graduate Medical School and Hospital of Columbia University. Sixty patients were studied. Forty were on low-calorie diets for ten weeks. Each patient received two massages a week on one limb. One deep hand massage for one-half hour and one massage with a Battle Creek Vibrating Machine for twenty minutes were administered. In the forty patients, there was a loss in the circumference of the limb which was massaged. There was a similar decrease in the measurements of the opposite limb, which was not massaged.

IN TWENTY patients with obesity—with no dietary restrictions, but who received body massage, there was no loss in body weight, and no decrease in the circumference of the limb, which was also massaged with a vibrating machine. It was concluded that general body massage, or local massage by means of a vibrating machine is ineffective in decreasing total body weight or the circumference of a limb in patients with obesity.

On the other hand, massage does act as a relaxant to most individuals, and is adjunctive therapy in many orthopedic problems. Much is said about massage stimulating circulation. I don't know what they mean by such a statement. An erythema is produced in the skin only and not in the muscles. It has been theorized that deep massage produces compression and relaxation of deeper vessels, thereby expediting venous return. Even if that were a scientific fact—how is the fat removed from the skin and muscles if fat is not transported through blood or lymph during such manipulation? Increasing red cells in the peripheral circulation is one thing; and increasing the transport of fat is another.

The beauty or "slenderizing" salons make all sorts of claims for the value of massage. What they don't show in their advertisements is the diet which they give and stress to the patient when she signs up for a series of treatments. Nor do they tell you about the medicine they insist that you buy as an adjunct to the massage. These are surprises which the patient gets on her first visit.

Many investigators have tried to produce mobilization of fat into the blood stream by increased tissue temperature and increased muscular work. These experiments showed little or no change in loss of fat tissue from the body.

Active exercise as a means to lose weight is of no value. To lose one pound, a person would have to walk at a fast pace without stopping, for a distance of thirty-three miles! Exercise has some value in increasing muscle tone. However, in a very obese individual, it would be futile to subject oneself to exercise until fifty per cent of the desired weight loss was accomplished. A muscle that is covered with a large layer of fat does not respond to the work load put upon it; hence, no toning of the muscle is accomplished until most of the fat is removed.

It is important that moderate or passive exercise be instituted with diet therapy in order to increase the energy expenditure. Any person who does her own housework and her own shopping, or one who has a job other than a sedentary one, is getting sufficient exercise.

IN CONCLUSION

THE nutrition quack or old time medicine man sold his cure-all youth-restoring patent medicines to any small group he could attract on a street corner, vacant lot, at picnics, fairs, or circuses. He was a small operator and worked under conditions of relatively limited communication and slow spread of public information. There was no radio or television to attract large audiences. Today, a barker on either of these two media can attract an audience running into the hundreds of thousands. Recently, I appeared on a television program and made a statement that 'I could sweep the dust off the floor, sterilize it and

put it in capsules. I could then hire a prominent advertising agency to go on a national hook-up selling 'Sterile Dust Capsules' for weight reducing and probably get good results in sales." Do you know what happened? I received requests from a number of people in New York, New Jersey and Connecticut asking where they could purchase "Sterile Dust Capsules," because the local pharmacist didn't have them. All of the people do not listen to everything that is said about a product on television or radio. Some of the people listen to part of what is said. It is this latter group that the barkers try to reach.

Medical science has made progress in understanding the problem of obesity. Definite contributions in the evaluation and treatment have been made by the biochemist, physiologist, nutritionist, endocrinologist, psychiatrist, and internist. It is a condition that is viewed today as the most important health hazard among us. In the past only the butcher, the grocer, the saloon-keeper and the capitalist were depicted as being corpulent. They had easy access to food or had plenty of money to buy an abundance of food. But today, supermarkets have made most of us our own grocers, butchers and tavern-keepers. We buy meat, groceries and refreshments in abundant quantities. As for capitalists, every laborer is a capitalist of some sort now. We have refrigerators—large ones, instead of small ice boxes of yesteryear. Freezers are becoming standard equipment.

There was a time when the lean and hungry person was looked upon as a neurotic individual. Today the fat person is labeled a frustrated patient. The obese individual can look forward to a rewarding future. The clinician, biochemist and physiologist are gearing themselves to a campaign of research in foods, nutrition, drugs, and psychotherapy for the benefit of the obese. Hypertension, atherosclerosis, coronary heart disease, diabetes, arthritis, gall bladder disease and other degenerative diseases will be reduced considerably when the results of the research on obesity are accomplished and applied to the patient. The food faddist and the quack, with their parasitic methods will be cast aside. A scientific and authentic approach to this medical problem will be the result.

The impulse to eat, which is the oldest impulse in the world, should be regulated but not stifled. The quest for food is the quest for life. Eating is a common characteristic of all living matter. Many of our physiologic functions are regulated automatically. Not so with eating. There is no regulator which automatically closes a sphincter in the esophagus or cardiac end of the stomach when we have had a sufficient amount of food, and open again when the stomach is completely emptied.

It is possible to run an automobile with a cheap grade of fuel, but its efficiency is enhanced when high test gasoline is used. Similarly, better nutrition education will produce less malnutrition and less obesity.

Start this education in infancy, for babies are born innocent of food habits. Personality problems frequently become manifested in adult life in the form of dietary indiscretions. That obesity shortens the span of life is common knowledge. Hippocrates remarked that those who were uncommonly fat died more quickly than the lean.

416 Clinton Place

Proper Postage for Laboratory Containers

Recent changes in postage rates affect the mailing of specimens to the State Department of Health. The amount of postage indicated on previous containers is no longer accurate. Postage to mail a single blood specimen container is now six cents. Proper postage must be applied to all containers to avoid delays in receiving and processing specimens. Consult your local post offices on the amount of postage to assure prompt handling.

Harris Blake, D.D.S.

Fred S. Blake, D.D.S.

Paterson

Plastic Closure of an Oro-Antral Fistula

Report of a Case

In removing the upper molars an oro-antral fistula may be an unexpected sequel. If this opening does not spontaneously heal, a plastic closure should be done. The Doctors Blake here tell how to do it.

In the removal of the upper molars the bone forming the floor of the maxillary sinus may be traumatized, resulting in an oro-antral fistula. This is often unavoidable due to the close proximity of the roots to the floor of the antrum. If the opening fails to close after three months, a plastic closure should be done. Where there has been a history of pus, closure should not be tried until suppuration has been arrested and adequate drainage established. With the aid of antibiotic therapy, the plastic repair will usually result in good healing provided the antrum is free of infection.

A 32-year old man was referred for examination of an oro-antral fistula in the region of the upper left first molar. Three months previously the left maxillary first molar tooth had been removed to which was attached the floor of the antrum. The patient complained about the escape of air around the gum on blowing his nose.

We found no discharge in his nose or mouth. He was in no pain. Examination revealed a small mucosal opening (Fig. 1) which, upon exploration, indicated that the floor of the antrum was absent in the area. The second and third molars were also missing on that side. Oral hygiene was good.

Roentgenograms disclosed clouding of the left antrum.

On the date of examination and for the following three days the patient received 600,000 units of penicillin intramuscularly once daily to clear the antrum of possible infection.



Figure 1. Oro-antral fistula in left molar region.

Operation—Before surgery, he was premedicated with secobarbital sodium 1½ grains and under local anesthesia, using 2 per cent Lidocaine® hydrochloride and epinephrine 1 to 100,000, the fistula was excised and enlarged to the size of the bony opening which was one centimeter in diameter. (Fig. 2) The bony edges of the alveolar process were smoothed and debris removed. A mucoperiosteal pedicle flap was outlined, prepared, and lifted from the hard palate, rotated, and placed over the area of the excised fistula. A small V was cut at the lesser curvature to prevent folding, and the pedicle flap was attached by means of interrupted triple O silk sutures. (Fig. 3) A dressing of surgical cement was placed over the donor area to protect the palatal wound and to relieve the tension on the sutures. At the conclusion of the operation the patient was given 600,000 units of penicillin intra-

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Figure 2. The fistula excised and enlarged to the size of the bony opening.



Figure 3. Mucoperiosteal pedicle flap from palate rotated over antral perforation and sutured.

muscularly. A gauze sponge was placed over the wound with instructions to remove it after a few hours. Extra-oral cold compresses were ordered. The patient was advised not to blow his nose, and to remain on a liquid and soft diet for a week.

He returned in 24 hours with slight swelling but no appreciable pain. Penicillin was again administered. Further treatment consisted of penicillin for the subsequent three days, saline mouth washes, high caloric diet and multivitamin therapy. Seven days after the operation the sutures were removed. The patient returned two weeks later and the fistula was found to be completely closed.

A description is given for the plastic closure of an oro-antral opening using a mucoperiosteal pedicle flap taken from the hard palate. With the aid of antibiotic therapy the plastic repair will usually result in good healing provided the antrum is free of infection. The mucoperiosteal flap taken from the hard palate consists of thick and firm tissue and has an excellent blood supply.

17 Church Street

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Deborah Tuberculosis Symposium

On November 20, 21 and 22, a symposium on tuberculosis will be held at the Bellevue Stratford Hotel in Philadelphia. At 9 a.m. Thursday, November 20 the seminar topic will be "Chemotherapeutic prophylaxis." The afternoon (2 p.m.) session will be devoted to the role of the hospital and home in tuberculosis management. On Friday, November 21, the morning session will discuss (a) the problem of relapse, (b) bacteriologic problems and (c) duration of drug treatment. The Friday afternoon colloquium will be centered on case finding technics. The Saturday morning panel (November 22) will discuss surgical aspects of the treatment of tuberculosis. Topic for the final session on Saturday afternoon is "The Future of Tuberculosis Control." There is no registration fee. Further details may be obtained from Dr. George N. J Sommer, Jr., at 120 West State Street, Trenton 9.

Victor Siegel, M.D.

Red Bank

Treatment of Peptic Ulcer Without Dietary Restrictions

A 97 per cent recovery rate is always worth reporting. Here, it is reported that 97 per cent of ulcer patients, without being placed on any diet, enjoyed a healing of the ulcer by simply taking hourly tablets of a magnesium trisilicate-aluminum hydroxide mixture.

Numerous investigators have sought a treatment for peptic ulcer without restriction of diet or limitation of alcohol and tobacco. With the availability of the aluminum hydroxide preparations in the 1930s there appeared to be a temporary solution of this problem. Then, in 1953, E. A. Marshall [1] presented an unrestricted diet regime. This stimulated the present study which was founded on a modification of the Marshall regimen. In the past 3 years, there have been many references in medical literature questioning the value of diet in peptic ulcer.

Sixty patients were included in this study. They were drawn from both white-collar and manual worker groups. A full medical history was taken followed by a complete physical examination. The series included 39 patients having their first attack; 12 patients having a second attack; 4 patients with third attack; and 5 patients for whom this was the fourth time with symptoms. All diagnoses were confirmed by radiologic studies. The histories suggestive of peptic ulcer obtained from these patients covered periods ranging from 20 years to 3 months.

Regardless of the duration of their disease, all patients included in this study were treated in the same way. (1) No dietary limitations or restrictions were imposed. The patients were told to eat whatever food they liked. There were no limitations imposed upon the use of tobacco or alcohol. (2) All patients were given a tablet or a teaspoonful of an aluminum hydroxide preparation every hour on the half hour, except at mealtime. Anticholinergics or antispasmodics were also administered in most cases, but in only a few instances was any sedation used. The dosage of the anticholinergic or antispasmodic compound prescribed was rapidly reduced and usually discontinued at the end of 4 weeks. The large doses of aluminum hydroxide which were used were constipating, so that preparations containing both aluminum hydroxide and magnesium trisilicate [2] were found to be most effective. The patients were continued on the regular dosage for 3½ to 4 months and then dosage was slowly decreased in amount until at the end of 5 to 6 months they were on no medication.

RESULTS

Fifty-eight of the sixty patients enjoyed excellent results from this treatment. All vol-

1. Marshall, E. A.: Exhibit at the June 1953 Annual Meeting of the American Medical Association.
2. The combination of aluminum hydroxide and magnesium trisilicate was supplied by Warner-Chilcott as Gelusil®

unteered information shortly after beginning treatment that they felt well and this feeling has been maintained.

Two patients are considered failures. One woman with a 5-year history of peptic ulcer, when last seen after 3 months of therapy, was in good health and eating everything for the first time in 5 years. Four months later, she had a partial gastrectomy for recurrence of symptoms. She had not been back to see me when her symptoms recurred. And a man with a 9-year history of ulcers and severe night pain which prevented him from sleeping for 2 weeks was admitted to the hospital vomiting and was found to have a partial pyloric obstruction. He was started on this therapy with immediate rapid improvement and after 24 hours slept through the night without pain. He did well for 15 months, then he developed complete obstruction and surgery was required.

COMMENT

Such well recognized complications of peptic ulcer as hemorrhage and perforation are not contra-indications to this form of therapy, as will be illustrated by the following cases:

1. A 27-year old man with fever of unknown origin developed a severe gastro-intestinal hemorrhage following administration of large doses of Prednisolone® and an injection of ACTH. He was given blood transfusions, continued on regular diet and aluminum hydroxide therapy with excellent clinical results. He has continued his Prednisolone® with buffered aspirin without bad effect for 18 months.

2. A 78-year old man with glaucoma had a duodenal ulcer with hemorrhage but without prior symptoms. He responded excellently to this therapy, without anticholinergics. It is now 14 months since his hemorrhage and he is well.

3. A 34-year old woman had had 3 previous bouts of hemorrhage from a duodenal ulcer. These had been treated in the hospital with the usual ulcer therapy. She began the aluminum-magnesium[2] therapy while still bleeding in her fourth attack. She was transfused and was discharged after one week, volunteering the information that this was the first time she had felt well on leaving the hospital.

4. A 41-year old woman had a 7-year history of ulcers and two prior bleeding episodes. She was treated at home with this regimen and has been well for two years.

5. A 44-year old man had a 10-year history of duodenal ulcer. He had had various forms of therapy. Suddenly he perforated. Surgery was done with closure of the perforation. Three days after the operation he was started on aluminum hydroxide and magnesium trisilicate[2] and became completely symptom-free, gained 30 pounds and felt well for the first time. Two other male patients who had no symptoms prior to perforation developed symptoms thereafter. They were started on therapy and responded very rapidly.

6. The first patient on this treatment was a man with a history of duodenal ulcer since 1942 with symptoms so severe that he was discharged from the army in 1944. On July 3, 1953, he began this treatment. One year ago he was divorced and volunteered the information that he had no abdominal distress through this entire episode. He has now been well for 4½ years.

7. An associate of this patient came to see me with a history of vomiting and gastritis as well as excessive alcoholic intake. Four weeks later, during Christmas and New Year holidays, he did not have any vomiting or symptoms of his duodenal ulcer or gastritis, despite continuance of his usual drinking habits. He has just returned from a 2-year sojourn as an engineer in Iraq and has been well the entire time.

SUMMARY

1. Sixty patients have been treated on an unrestricted diet accompanied by regular dosage of aluminum hydroxide and magnesium trisilicate.[2] Most of these patients were given an anticholinergic or other antispasmodic for the first three or four weeks of treatment.

2. Fifty-eight of the patients had excellent therapeutic results from this regimen. Two went on to surgical treatment.

3. Unrestricted diet, when accompanied by proper therapy appears to be a successful method of dealing with acute peptic ulcer.

4. In my hands, a preparation containing aluminum hydroxide and magnesium trisilicate[2] was found to be most effective without producing troublesome constipation.

292 River Road

Archie Crandell, M.D.
John Y. Ma, M.D.
Greystone Park

The Management of Tuberculous Patients In Mental Hospitals

Outside of the tuberculosis sanitarium, the greatest incidence of pulmonary tuberculosis is found in the mental hospital. The patient thus afflicted is truly a man with a double cross to carry. In this brief paper, Dr. Crandell and Dr. Ma describe the control program at New Jersey's largest hospital.

Mental hospitals constitute one of the greatest reservoirs of active tuberculosis in this country. The incidence varies. Occhesli[1] made a survey in 1945, and reported an incidence of 8.25 per cent. Three quarters of these belonged to the schizophrenic group. Whether the schizophrenic patient is particularly susceptible to tuberculosis is debatable, inasmuch as the schizophrenic group occupies the majority of beds in mental hospitals.

Death rate is an important index of long-range effectiveness of any tuberculosis control program. Any progressive decline in the death rate is, presumably, due to the effectiveness of the program. In 1946 the death rate of tuberculosis among the general population was 36.4 per 100,000. In the same year the death rate among mental patients was 668 per 100,000. A re-survey by Occhesli[2] in California indicated that in 1950 the death rate of tuberculous patients in mental hospitals fell to 482, with a further decline in the following year to 366.

Some patients recover from the psychosis but are still afflicted with active pulmonary tuberculosis. If they no longer require hospitalization for psychiatric treatment, they cannot be detained in the mental hospital by reason of active tuberculosis. When these patients return to the community they present a serious epidemiologic problem. The control of tuberculosis patients is an essential and urgent step in a mental hospital program.

CHEST X-RAY SURVEY

Case finding for tuberculosis is the keynote to its control. Chest x-ray surveys are the primary steps toward this goal.[3] X-ray surveys consist of radiographic examination of all patients in mental hospitals as well as personnel, every six months, and of all new admissions, in order to screen out active cases.

1. Occhesli, W.: Tuberculosis Control Program of Nine California Mental Institutions, Public Health Report, 17:3 (March 1, 1946).
2. Occhesli, W.: Resurveys of Patients in California Mental Institutions, Public Health Report, 25:560 (Dec. 1, 1954).
3. Garland, L. H.: American Journal of Roentgenology, 64:32 (1950).

Various size films are used: 35 mm., 70 mm., or 4 by 5 inch films. The 14 by 17 films are used only in doubtful or positive cases. Several commercial companies are available for survey purposes, such as the National X-Ray Survey Corporation. They operate on a contract basis which is easy and convenient of administration. In Greystone Park this method has been adopted since early 1951. Records indicate that the incidence of tuberculous patients in 1951 was about 12 per cent. Recent survey indicates a decrease to below 5 per cent.

ISOLATION

THE best way of eliminating tuberculous infection is isolation. All positive cases should be segregated and classified according to activity. In chronic psychotics, in over-populated parts of state hospitals, it is suggested that those patients reside in different buildings which are modernly equipped, staffed by trained personnel. At Greystone Park we receive many patients with tuberculosis from other hospitals. We have three buildings in which to house these patients, according to the activity of their tuberculosis. Each employee working in active tuberculous areas is capped, masked and gowned. This is essential for protection, and it has proved to be a satisfactory method. In this way, the incidence of tuberculosis among our employees has been minimal. It is believed that tuberculosis sanatoria should be near well equipped hospitals because there are so many skilled clinicians available. There is a trend toward the centralization of care and treatment for active tuberculous cases among mental hospitals. This can improve in many ways the treatment as well as control of tuberculous patients.[4]

DIAGNOSIS

THE next important step is diagnosis. Tuberculin tests are significant if tuberculosis infection is suspected. Such tests should be applied to all positive cases as one of the preliminary steps. It is best to have all new admissions given this test. When results are negative, those patients should be re-tested at least once a year.[4] This is a valuable index to the efficiency of tuberculosis control. The Mantoux test is preferable, using either PPD or OT. However, we have found the patch test (Vollmer) is satisfactory, also.[5] The handling of sputum is somewhat different than in general hospitals because so many psychiatric patients are unable to cooperate. Sputum collections are regularly carried out from patients who are in better contact. Gastric lavage is a better method for non-cooperative patients or for those unable to produce sputum. These patients should be moderately sedated or even temporarily restrained. We have no experience in tracheal lavage which is perhaps more accurate than gastric lavage.[6]

SPECIFIC THERAPY

WITH the advancement of anti-tuberculous drugs we are able to treat mental patients just as successfully as non-mental patients. Streptomycin, para-amino salicylic acid and isoniazid are the popular drugs. The dosage, method of administration and duration of treatment correlates with current methods.[7] Isoniazid in large doses may cause overactivity.[8] The relatively safe dose is up to 4 milligrams per kilogram of body weight. Because of the restlessness and poor cooperation of many mental patients a longer period of treatment is necessary. We have successfully given anti-tuberculous drugs for over two years without ill-effects. Because of the patient's mental condition, subjective improvement is

4. Report of the Committee on Chest Disease in Institutions, American College of Chest Physicians. 1957. Philadelphia.

5. Diagnostic Standards and Classification of Tuberculosis, National Tuberculosis Association. Chicago 1953.

6. Hinshaw, A. and Garland, L.: *Diseases of Chest*, 28:419 (1956).

7. Editorial: Present Status of Chemotherapy in Tuberculosis. *Diseases of Chest*, 27:582 (1955).

8. Biehl, J. P. and Nimitz, H. J.: American Review of Tuberculosis, 70:430 (1954).

not always a reliable criterion. The patient may not be adequately communicative. In such cases, roentgenologic and laboratory examinations are more helpful in determining the degree of improvement during the course of treatment.

COLLAPSE THERAPY

Collapse therapy is of considerable value in the treatment of tuberculous patients who are mentally ill. In selected cases it has led to remarkable results. Artificial pneumothorax and pneumoperitoneum [9] have been used successfully and safely in many cases. A small proportion of patients may require pre-pneumothorax sedation, but generally the patients become adapted to the procedure quite well. We have found results satisfactory [10] without combining phrenic nerve interruption.[11] Collapse therapy is more favorable when combined with anti-tuberculous drugs [12] such as streptomycin, and isoniazid and para-amino salicylic acid.

SURGICAL THERAPY

With the improvement of surgical technics as well as the introduction of tranquilizing drugs, surgical treatment for mental patients is quite possible and successful. When the psychotic condition is under control and surgical treatment is indicated the patient should be transferred to a hospital where these facilities are available. With the discovery of late complications after pulmonary resection its popularity showed slight decline, and many phthisiologists returned to collapse therapy.[13] This is still a controversial question. For mental patients, however, collapse therapy continues to be one of the most effective procedures, especially when their mental condition does not warrant surgical intervention. Of course, it would be more convenient if mental hospitals were equipped with chest surgical units.

TRANQUILIZING DRUGS

Tranquilizers have opened a new door for the mentally ill.[14] By now there are dozens of such drugs. The most popular are promazine, chlorpromazine, meprobamate and reserpine. Last year, we reported [15] on a study of reserpine in mental patients who had tuberculosis. We treated 63 patients who also had active or inactive pulmonary tuberculosis. We tried parenteral or oral method for two and a half to ten months. We found that reserpine caused no ill effects. When these patients had adjusted well enough to leave the hospital and their pulmonary tuberculosis was no longer active they were referred to private physicians for continuation of the treatment with supervision. If their tuberculosis was still active and they were no longer psychotic these patients were transferred to tuberculosis sanatoria. There is a potential risk in the use of electric or insulin shock therapy on tuberculous patients. We are now able to replace this method by using the tranquilizing drugs alone.[16] Patients on tranquilizing drugs eat and rest better and gain weight. Many of them show roentgenologic improvement. Thus, we find that tranquilizing drugs aid indirectly in the treatment of tuberculosis. Many patients who are receiving tranquilizing drugs are also taking anti-tuberculous drugs such as streptomycin, PAS and isoniazid. This can be done without evidence of incompatibility. The dosage of the tranquilizing drugs has to be tailor-made for the patient. A fair trial period of three months on one of the products might be

9. Banyai, A. L.: Pneumoperitoneum Treatment. C. V. Mosby, St. Louis, 1946.
10. Hinshaw, A. and Garland, L.: *Diseases of Chest*, 28:491 (1956).
11. Mitchell, R. S.: American Review of Tuberculosis, 60:183 (1949).
12. Trimble and Eaton, *Diseases of Chest*, 27:1 (1955).
13. Hinshaw, A. and Garland, L.: *Diseases of Chest*, 28:483 (1956).
14. Wilmer, Harry A.: This is Your World. Springfield, Illinois; Thomas, 1952.
15. Crandell, A. and Ma, J.: American Review of Tuberculosis, 74:3 (Sept. 1956).
16. Pleasure, H.: American Journal of Psychiatry, 110:3 (Sept. 1954).
17. Feldman, P. E.: American Journal of Psychiatry, 113:589 (Jan. 1957).

advisable. If the patient shows no definite improvement, he can then be changed over to another drug until satisfactory results are achieved. In our study, we found that no single diagnostic category responds outstandingly to any one drug. Patients who do not respond to one drug may respond to another, and those who reacted moderately to one may respond maximally to another. Hyperactivity, combativeness and tension respond best to tranquilizing drugs.

SUMMARY

MENTAL hospitals are great reservoirs of active pulmonary tuberculosis. An effective control program would be chest x-ray surveys of all patients, including new admissions as well as personnel and isolation of positive cases according to activity. This would be more effective, both in control and treatment, if the State would centralize all tuberculous patients from its mental hospitals in one well-equipped, modernized hospital. The tuberculin test may be applied to suspicious cases and it would be preferable to have all new admissions tested. When results are negative the patient should be re-tested at least once a year. We use chemotherapy to treat mental patients just as successfully as non-mental patients. High dosages of isoniazid may cause overactivity in these patients. Roentgenologic and laboratory examinations are more reliable in determining the degree of improvement especially when the patient is uncommunicative. Pneumothorax and pneumoperitoneum are equally effective in treating carefully selected cases. When the mental condition of the patient is well under control and surgical treatment is indicated the patient can be treated as a non-mental patient. Tranquilizing drugs have made many of these patients more manageable. As a result of this new treatment for their mental condition it may be possible to replace electric and insulin shock therapy with tranquilizing drugs. Because of the improvement of the patient's mental and physical condition, these drugs also aid indirectly in the treatment of tuberculosis. There is no incompatibility noted when tranquilizing drugs and chemotherapy are used concurrently.

THE STATE HOSPITAL

Smallpox is Still Here

Eighteen countries were infected with smallpox by international travellers in 1957. Eight suffered epidemics of this quarantinable disease, according to the World Health Organization *News* for November 1957. The WHO warns against relaxation of vaccination measures against smallpox and called for the use of potent vaccines as well as correct vaccination procedures. WHO stresses the need for medical personnel who come in contact with travellers to maintain a high level of immunity against smallpox by repeated vaccination. Already several doctors treating tourists have caught the infection and died.

WHO experts call attention to the advantages of dried smallpox vaccine for mass campaigns. Dried vaccine is easily transportable, remains effective without refrigeration and does not spoil.

The eight countries where smallpox epidemics took place were: Ceylon, Ghana, Iran, Italy, Lebanon, Sierra Leone, Sudan and United Kingdom. The countries where smallpox was imported without spreading to the population were: Argentina, Germany, Greece, India, Iraq, Jordan, Netherlands, Paraguay, Syria and Uruguay.

Sidney Keats, M.D.*
Newark

The Pathology of Low Back Disorders

This talk was prepared for presentation to attorneys and workmen's compensation referees and commissioners. It is, however, of general interest to all physicians who deal with lower back pain.

In the management of low back disorders, the most important first step is the establishment of an accurate diagnosis. Exact diagnosis can be made only with a thorough knowledge of the changes in the integrity of the tissues of the back caused by trauma. Let us then consider two of the most common injuries to the lower back. *First,* soft tissue injuries, in which the fascia, muscle and ligaments are involved; and *second,* injuries to the spinal joints, including the interarticular and the lumbo-sacral joints.

ANATOMY

The function of the back is to supply stability, flexion, extension, lateral motion and rotation of the trunk. The spinal cord is enveloped and protected by the neural arches of the vertebrae. The intervertebral discs act as shock absorbers, to minimize the transmission of shocks to the spinal cord, brain, nerve roots. They also maintain the integrity of the intervertebral joints, and the foramina of the spinal nerves.

The vertebrae are bound together by strong anterior and posterior common, or longitudinal ligaments. These resistant ligaments extend from the sacrum to the occiput, and practically cover the bodies of the vertebrae, and the intervertebral discs. The ligamenta flava are strong elastic ligaments which run along the posterior surface of the spinal canal and attach to the laminae. The intertransversalis and interspinous ligaments connect the transverse and spinous processes. The deep muscles of the back and trunk are covered by the lumbodorsal fascia which continues upward to the neck. The muscles of the back perform two functions—the maintenance of posture, and movement. Flexion of the spine is produced by the contraction of muscles that are situated anterior to the spine—the abdominal muscles, assisted in part by the psoas and quadratus lumborum muscles. Extension of the spine is accomplished by the extensor muscles situated posteriorly. These include the semispinalis, erector spinae, multifidus, rotatares, interspinales, serrati posteriores, splenius and levator anguli scapulae and the upper fibres of the trapezius. The motor system of the back is maintained in balance by the harmonious function of the nerves, muscles, tendons, bones and joints. If the muscles on one side of the back contract more powerfully than those on the opposite side, lateral flexion of the body, or bending with rotation results. Scoliosis, then, may be a sign of imbalance of muscle, as well as of bony growth.

*Presented at Symposium on Low Back Disorders, sponsored by State of New Jersey, Department of Labor and Industry, Academy of Medicine of New Jersey, Newark, New Jersey, December 4, 1957.

SOFT TISSUE INJURIES

INJURY to the fascia of the back may be caused by direct or indirect violence. Injury may cause an acute fascitis, which may resolve itself; or it may cause a chronic fascitis, with contracture of the fascia, resulting in considerable pain and incapacity. The tissue changes may extend to the underlying muscles, in which event, a myofascitis may result. As a result of trauma, the fascia investing the back muscles may be torn, the fibres separated, and the muscles underneath may extend through the opening to form a muscle herniation. A muscle strain may vary from a mere stretching of a few muscle fibres with mild complicating symptoms, to a rupture of a substantial portion of a muscle. In such cases, the torn muscle fibres heal by replacement of the elastic tissue by hard, fibrous, non-stretching tissues, which results in interference with the harmonious contraction of such muscle. This process, in some, but fortunately rare cases, may progress to a state of calcification of the torn fibres. This is known as myositis ossificans. Injury to the ligaments of the back may vary from small tears to extensive violence, in which the ligaments are torn away from their attachments to the bones.

BACK STRAINS

A STRAIN is a local condition due to the application of an unusual mechanical force to normal tissue, or an ordinary force acting on weak tissue. The force usually catches the tissues "off guard," and results in some tearing of the fascia, muscle, or ligament. The aftereffects of a strain may be mild, and the tissue under the microscope may show little organic changes. On the other hand, if the traumatizing force is persistently severe, an effusion of blood may result. This effusion may then become organized. In the healing process, adhesions and scar tissue may develop, with pain and impairment of function. Chronic strains are usually due to occupational or postural burdens placed on normal or pathologic tissues. Any force which suddenly or slowly stretches the tissues beyond their normal resisting strength will lead to tearing of the tissues. The strain is usually in the lumbar, lumbo-sacral or in one of the sacro-iliac areas.

CONTUSIONS

A CONTUSION of the back is commonly due to a direct blow or a violent fall. It may cause hemorrhage into the muscle fibres, or, into the fascia, or even rupture of the muscle belly. Muscle rupture, however, usually results from indirect violence and may vary from a slight separation of the muscle fibres to complete disruption of the muscle substance. Such indirect violence is thought to occur in a contracted muscle when the antagonist muscle group is brought into action. This may occur through lack of coordination of muscle balance, or when a sudden and unexpected movement takes place in response to surprise or for protection. The occurrence of this type of injury is aided by a state of fatigue in the muscle substance.

BACK SPRAINS

THE term sprain may be applied to a joint that has been suddenly twisted or wrenched, stretching the ligaments investing the joint, until they tear or become separated from their attachments. A sprain is painful because it is essentially an injury to the nerve endings in the periarticular structures. A sprain denotes injury to the component parts of a joint, including the muscles. The following tissues enter into the formation of a joint: bones and articular cartilage, capsule and the synovial membrane, ligaments for support and limitation of excess motion, muscles for movement, fatty tissue, blood vessels and nerves.

The most common of low back injuries is lumbosacral sprain. The lumbosacral region is vulnerable to injury for many reasons. It is the site of abrupt transition between the freely

mobile lumbar spine, and the immovable sacrum and pelvis. The lumbosacral joint bears the superincumbent weight of the body, and is thereby subjected to greater stress. This susceptibility to injury is frequently enhanced by the presence of congenital structural anomalies. All things being equal, in the presence of congenital anomalies, it takes less trauma to produce a given disability. On the other hand, a given trauma may cause greater and more prolonged disability in the potentially weakened spine.

The intervertebral joints and their ligaments are of paramount importance in the lumbosacral area. Upon their integrity depends the stability of the vertebral column, and the efficient movement of the trunk. Fifty per cent or more of the movement of the trunk, below the thoracic region, occurs at the lumbosacral joint. The powerful lumbosacral and iliolumbar ligaments, enveloping structurally weak joints, are endangered whenever even momentary protection is lost. This may occur when the muscles relax, just before a strong muscle contraction, or when the subject is in the flexed or twisted attitude, positions which predispose to greater strain on these ligaments.

The lumbosacral joint, anatomically, is vulnerable to stress and strain, because it is the juncture of the mobile and the immobile part of the spine, and because it is the site of tremendous shearing strain. As long as the muscles and ligaments are of sufficient strength and tone to enable the person to continue his activities at this level without tissue fatigue, there are no symptoms and the back is in a "compensated" state. "Decompensation," and back pain, result from a failure of the muscles and ligaments to withstand the stress and strain in supporting the lumbosacral joint. Lumbosacral anomalies will produce symptoms when this balance is disturbed by faulty mechanical forces.

The lumbosacral angle varies within wide limits in the normal. The angle at which the lumbar spine articulates with the sacrum varies from 90 to 140 degrees. The average downward inclination at the lumbosacral joint is estimated at 42.5 degrees, when the person is standing erect. Were it not for the articular facets of the sacrum, in which the lower articular processes of the fifth lumbar vertebra fit, and the strong supporting ligaments, the lumbar vertebrae would slide forward on the sacrum. Anatomic variations, which commonly cause weakness of the lumbosacral joint, fall into two groups: (1.) Increased sacral inclination. (2.) Such congenital anomalies, as variations in the articular processes of the articular facets or processes of the lumbosacral joint, spina bifida occulta, enlarged transverse processes, sacralized transverse processes, and lumbarization of the first sacral segment, and spondylolisthesis.

SPONDYLOLISTHESIS

ANOTHER anatomic variation in the lower back which predisposes to weakness, is that condition known as spondylolisthesis. Spondylolisthesis means slipping of a vertebra. Diagnosis is made by x-ray. Two requirements are necessary to establish the diagnosis: *first,* demonstration of a defect in the pedicle of the neural arch; *second,* a slip of the body and the anterior portion of the neural arch, while the posterior portion of the arch and the spinous process remain *in situ.* Anterior displacements most commonly occur at the lumbosacral joint, less commonly at the junctions of the fourth and fifth, and the third and fourth lumbar vertebrae. Forward displacement of the fifth lumbar vertebra on the sacrum may develop early, or late in life. The anomaly or the defect is primarily congenital, but the actual forward displacement is due to superimposed trauma. No instance of a true congenital forward slip has been reported in a new-born child. The defect in the neural arch is usually bilateral. As a consequence, the stability of the vertebral column is markedly diminished by interference with the integrity of its bony moorings. This loss of bony anchorage produces an increased shearing stress at the joints involved, and puts a heavier burden on the supporting muscles and ligaments.

Almost all observers agree that trauma in

some form is the direct cause of the lesion. In other studies, diving, landing on the buttocks in the sitting position, occupational and postural strain, and constant labor have been identified as the causative mechanism. In the medical literature of Great Britain, spondylolisthesis is commonly referred to as "miners' back," because of its prevalence in persons performing heavy manual labor, especially the coal-heavers employed in the mines of Wales. Spondylolisthesis, then, is another frequent anatomic variation at the lumbosacral junction which predisposes the lower back to trauma.

31 Lincoln Park

Association of Medical Assistants

The American Association of Medical Assistants is made up of men and women employed as assistants in physicians' offices. The Association was established in 1955 when interested persons from fifteen states met to develop a formal organization. At the 1956 meeting in Milwaukee, a Constitution and Bylaws were adopted. A convention was held in San Francisco in 1957. Now, with a membership of nearly 6,000 and with the approval of the American Medical Association, this Association is well under way.

The purposes of the Association are (1) to inspire its members to render honest, loyal and more efficient service to the profession and to the public; (2) to strive to cooperate with the medical profession in improving public relations; (3) to render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation; (4) to encourage and assist all unorganized medical assistants in forming local and state societies. This Association is not a trade union or collective bargaining agency.

Several states now offer fine educational courses with the cooperation of their colleges and universities which will help the assistant to become more valuable in the doctor's office. The well-trained assistant is an asset to the doctor. These courses relieve physicians of much of the time-consuming work of on-the-job training. The Association will offer courses on a national level as soon as a curriculum has been set up.

Membership has provided an opportunity for the assistant to benefit from the many fine lectures, workshops and seminars as a part of regular programs.

The American Association of Medical Assistants is now offering its members a comprehensive insurance program. This is a salary replacement (sickness and accident) plan with optional major hospital, nurse expense and surgical benefits.

It is to the advantage of the medical profession to have their medical assistants affiliated with this organization.

The American Association of Medical Assistants welcomes the opportunity to give information concerning the organization and to assist with the formation of county and state societies. Inquiries may be addressed to Miss Hallie Cummins, Medical Record Library, State Hospital, Caro, Michigan.

Henry A. Davidson, M.D.

Cedar Grove

The Doctor's Personality as a Factor in Medical Care*

The doctor's personality is a factor in the kind of medical care he gives. Emotions influence organic disease by affecting vascularity, tonus and secretions. The physician's personality influences the patient's emotions. The physician's personality exercises an effect on the patient's welfare.

At the medical school commencement, the orator typically tells the new graduates: "You must give of yourself to practice good medicine." This implies that the doctor's own personality is a kind of medicine which, like all medicines, can be given in small or large doses, can be given crudely or with artistry, can produce powerful results, and can cause side effects. And this is not limited to emotional illness, either.

Consider anxiety. This is an emotion, and like anger, fear, or frustration, it has the sponginess of a ghost. You cannot weigh anger, you cannot palpate frustration the way you can palpate a liver. You cannot see affection on the x-ray, or hatred in the microscope. These emotions are indeed such stuff as dreams are made of. They are wraiths; invisible, imponderable, and impalpable.

But do not sell them short. Anger can raise your blood pressure. In response, your blood vessels can stiffen to resist the rising pressure. So, something as invisible and impalpable as anger can lead to something as tough as arteriosclerosis. Frustration can increase gastric acidity and gastric motility, thus leading to ulcers. And an unrelieved ulcer can perforate and cause fatal peritonitis.

Thus, the emotions can influence not only the functional diseases, but also organic diseases. Anger, rage, hostility, or frustration can lead to an ulcer or a fatal peritonitis, to hypertension, and to many other conditions. Some years ago, a prisoner who had been sentenced to life imprisonment was dying of a metastatic carcinoma. His one wish was to die at home and not in a prison. The prison physician persuaded the Governor to pardon the man on the representation that the prisoner was moribund and completely bedridden. The doctor told the prisoner that his pardon would come through any day, and he could then be ambulanced home. However, due to red tape, the pardon was very slow in coming. The man should have died within 24 hours. Actually, he survived four full days, and not until the beginning of the fourth day did the pardon come. He was taken home, and died six hours later.

What kept the man going during those few days was a repeated self-injection of epinephrin. His own adrenal glands kept working overtime during this four-day period, spurred on by hope. This kept him alive by giving him that drug. While life cannot be prolonged indefinitely this way, it is a dramatic example of how an emotion like hope can measurably prolong life. A doctor's ability to produce this

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kind of emotional reaction is related to the patient's ability to survive; and where the disease is a borderline one, the doctor's personality may make the difference between recovery and death.

That may sound fantastic, but certainly there *are* diseases where recovery hangs in the balance in a crisis. Surely the patient's own hope and enthusiasm on the one hand, or despair and willingness to give up on the other, may tip the balance. These reactions are related to the doctor's ability to handle his own emotions. So it is that the doctor's own personality plays a role in the treatment of patients even in organic disease.

In diagnosis, you might suppose that we deal with a purely rational operation. Presumably the doctor's personality would not be important in deciding whether a difficulty in walking is due to tabes dorsalis, or to poliomyelitis. However, there *is* a large area in which the physician's prejudices, whims and preferences *do* play a role in diagnosis.

DISABILITY AND THE DOCTOR'S PERSONALITY

WE LIVE in a disability-conscious world. If a doctor finds disability, all kinds of good things may happen to a patient. He may get health insurance money or free hospitalization. He may get Veterans Administration compensation or pension. He may collect benefits from his trade union. He may be excused from unpleasant work. Diagnosis of a disability or of the cause of the disability becomes important in doctor-patient relationships and, indeed, in our whole economy.

Can a truly objective doctor make such decisions solely on the basis of the objective evidence? It is alleged that if three honest doctors examine a patient, they will all agree in the finding that this patient has a specified type of heart disease, which definitely is or is not associated with this particular emotional or physical trauma. This is not true. Whether a doctor is willing to say that this disability is significant or insignificant depends on his whole orientation. Whether an examiner is willing to say that this condition is hysterical, or due to organic disease, or is malingered, is often due as much to the doctor's own personality as it is to the facts in the case.

I know a midwest dermatologist who comes from a fine family. A wealthy man in his own right, he is professor of dermatology at a school. He numbers among his close friends many judges and civic leaders. He was telling me that he was annoyed at a "shyster lawyer" trying to get compensation for a man who suffered a weeping eczematous rash every time his skin came near gasoline. My dermatologist friend exploded indignantly at the lawyers who were trying to say that he had a permanent disability. "Ah," said the dermatologist, "this man has no permanent disability, because you can clear his skin up at once by taking him away from the vapor of gasoline." I was told that he was 46 years old, and that he was an oil chemist. I pointed out that a 46-year old oil chemist who has to give up his occupation does have a very serious disability because, at that age, he isn't going to learn a new branch of chemistry or find another good job. And if he is physically prevented from earning his living at the one thing he knows, his disability is serious indeed. The dermatologist, however, pooh-poohed all that, and said that as far as he was concerned there was no permanent disability.

This dermatologist was telling the truth as he saw it. He was not venal or incompetent. This is what he saw; this is what he believed. I cite this to illustrate that you *can* have honest disagreement among doctors, and also to show that the personality of the doctor is involved in diagnosis and prognosis.

By contrast, I think of another man, now a successful orthopedist in the far west. When my orthopedic friend was a youngster, his father was a labor union official. The boy was brought up to believe that every employer was a greedy capitalist bearing down heavily on his employees. My young friend was employee-oriented. He thought that the typical workman was nature's gentleman being ground down by a grasping employer.

His father, in spite of being a ground-down employee, managed somehow to send my young

friend to medical school. In his orthopedic residency, he met and married the daughter of an insurance company executive.

Once in private practice he was, through his father-in-law's connections, able to affiliate with an insurance company. They sent him their compensation work. From the first, however, it was apparent that he would never do. This doctor would give a higher evaluation for disability than the employees themselves asked for. After a few months, the insurance company stopped using him.

This orthopedist was claimant-oriented. Though it was much to his own interest to change his orientation, he was unable to overcome the effects of a whole childhood of employee orientation.

I give you these two crude examples to illustrate the point that in making a diagnosis and a prognosis, the doctor's own personality and his background play a role. This is another way of saying simply that doctors are human, and they cannot escape from their humanness.

More and more medical practice is going to be in an area where you must submit reports to obtain payment from a third party. This gives a whole new dimension to medicine, as it is already doing in England today. The misanthropic doctor will feel that the average patient is out to get something for nothing and that he, the doctor, is not going to be fooled by it. Under those circumstances, the misanthropic doctor is going to be down-playing the disability. He will make a diagnosis of psychoneurosis more often than of sacro-iliac sprain. He is going to say "malingering" more often than "psychoneurosis." His generally sour feeling about human nature will reflect itself in his diagnosis.

Conversely the doctor like my orthopedic friend, who is rather optimistic and philanthropic about people, will be finding disabilities and diagnoses even when they don't exist. Diagnosis is not a rational matter based on the weighing of objective findings and test results. In the day by day practice of medicine, a large proportion of the symptoms are not readily classified. Think yourself of the last twelve patients you've seen, and of what they were complaining about. I think you will find that most of the complaints fall in the area of headache, weakness, dizziness, loss of strength, trouble in sleeping, backache, abdominal discomfort, flatulence, and other non-heroic symptoms in that group. If you review this list, you will also see that while these symptoms may be due to organic illness, they generally do not suggest any such thing to the doctor. Here again, you see, is the scope for the doctor's own personality. The doctor's personality may also reflect itself in his technic of asking questions. A lot of medical diagnosis depends on good history-taking. Good history-taking turns on skillful questioning. The doctor who because of good technic, or because of his own personality, elicits a detailed history, is going to be more accurate in his diagnosis than one who merely takes a present illness and traces it back to its apparent and recent origin.

STRICTLY CONFIDENTIAL

One of the major manifestations of the doctor's temperament is his willingness and ability to handle deep confidences. Traditionally, the doctor-patient relationship has always been a sacred one, though in New Jersey it is not legally privileged. You might think, then, that the physician is quite accustomed to receiving patient's innermost confidences, and taking this in stride. Actually, it is not that simple. While the general practitioner still flourishes, the family doctor does not. The patient's confidences are divided among a whole staff of physicians. There is not much of a problem when it comes to confidences about physical illness—even such things as the onset of venereal disease. The trouble comes when the patient starts pouring out his private life to the physician, roaming far afield from day-by-day medical problems. It is what in police circles is vividly, if inelegantly, called "spilling one's guts." People with emotional problems are under pressure to pour out words. They desperately want to talk to someone who will listen sympathetically. They do not really want advice. What they want is a sounding-board.

Sometimes the clergyman serves that purpose —sometimes it is an Uncle Dudley—but oftentimes it is a doctor of medicine.

You might think that this involves the patient's emotions only, not the doctor's. But there is more to it than that. If you "spill your guts" to someone, he suddenly has power over you. If you had anything to be ashamed of, you may have trouble looking him in the face hereafter, even if he wears the vestments of a priest or a physician. Sometimes the patient feels almost despoiled at having so unburdened himself. The doctor's adroitness in handling this is a real test of his artistry. His own tensions, his comfortableness at subsequent meetings with the patient, his ability to show interest while listening without at the same time seeming to drool over gossip, are all related to the physician's own personality, and thus to his skill in handling the patient in this situation.

There is another aspect to this handling of confidences. The preservation of human dignity is part of a good working relationship with other human beings. The doctor sees the executive with his pants down, a posture in which it is difficult to preserve dignity. People resent an invasion of privacy. There is, however, a difference between the privacy of the body and the privacy of the soul. When you do a sigmoidoscopy, you invade the patient's privacy—literally so, since the rectum, like the scrotum, is traditionally a private part. But this invasion is not nearly as threatening as when you get information about a man's sexual or spiritual behavior, or, for some men, even about their alcohol habits. Here again, the doctor's own personality is dramatically projected on the scene.

WHAT IS A NEUROTIC?

A LARGE part of the general practitioner's work is the care of neurotics. Here the doctor's personality becomes even more of a factor than it is with organic diseases, though it plays a role in organic disease too. But ask yourself what you really think of the neurotic.

There are three ways of looking at the neurotic. The psychoneurotic is a sick man; he has a worse illness than many persons with organic disease. The doctor can feel sympathetic toward the neurotic; he can thank God that he is not a neurotic himself. He can feel that he has a solemn duty to do what he can to help the neurotic. This represents the gentle view of the neurotic. Then there is the intermediate position, which holds that this suffering is self-inflicted, and is due largely to the fact that he has too vivid an imagination. According to this view, the way to handle the neurotic is not to sympathize with him too much, because that will only coddle him and feed his psychoneurosis. The doctor who takes this position has a certain brisk sympathy for the neurotic. He is glad he is not neurotic himself, and he accepts the duty to help the neurotic get well. However, he believes that the symptoms are essentially imaginary, and that nothing should be done which will make the patient brood or even take himself too seriously.

Finally, there are doctors who believe that the neurotic is a malingerer—sometimes consciously, sometimes unconsciously. They take the position that the best thing you can do to a neurotic is to destroy his dependence on the physician or on the family. They think he is like a man who can swim, but is afraid to try. They want to throw him into the water, on the theory that rather than drown he will swim, and that this will be the best thing in the world for him. Doctors in this group say that our culture makes the neurotic too much of a parasite. They believe that health insurance and sick benefits and compensation and pension all make the neurotic so dependent that he never learns responsibility. They argue that the doctor's real duty to the neurotic is to toughen him, and that this is done by denying that he has any illness, and insisting that he go out and fight for a living.

Thus, the doctor's attitude toward the neurotic is dependent on the practitioner's own personality, and not alone on the facts of the case. The facts are the same, but they certainly are read differently by different doctors.

If we want to preserve the personal touch, and if we value the differences in personalities among ourselves, then we must also face the fact that we can never make a diagnosis with cold impartiality. Honest doctors may disagree violently about diagnosis and treatment; and there will be no absolute objectivity in this field. It is healthier for us to recognize this, than to pretend that we are operating in a cold intellectual vacuum. And when there is litigation, we should seek not for an impartial physician, but rather for two partisan physicians who are honest, and who can present their own points of view, subject to cross-examination. This is healthier than the vain effort to seek an absolutely impartial medical witness.

I wonder how many of you realize the extent to which administrative tribunals are making decisions about medical diagnosis, prognosis, and disability? There are obvious examples, such as army retirement boards, Veterans Administration claim boards, and the like. There are less obvious examples in industry, where somebody has to make a decision about a worker's diagnosis and disability. Recent laws also provide benefits when workers are totally disabled, and the Social Security laws in turn need a medical adjudicator to administer them. There is an ever-increasing field of medical adjudication, and here is where the impartiality of a physician becomes a major issue.

If one kind of doctor makes the decision, people who complain of vague disability may be retired at a very early age, either against their will or in accordance with their wishes. If the tribunal had a different kind of doctor, he might find no justification for medical retirement. This is true of army retirement, Veterans Administration compensation, and even justification for hospitalization under health and hospital policies. In all of these areas the adjudicating physician wields a tremendous power. And his decision depends a lot on his personality.

Here is a tribunal on which the single doctor makes the decision as to whether somebody gets compensation or pension, or is excused from work. Dr. X believes firmly in rugged individualism. He is scornful of people who are weak, and who whine or say that they are sick when they have trivial symptoms. Obviously, Dr. X cannot be impartial. Though he boasts that he calls the shots where he finds them, you and I know that his decision is influenced by his bias. But if he puts on the halo of impartiality, he will have a tremendous influence on the executives who have to make decisions about this worker's disability. The matter could also be disposed of by having two doctors, one on each side, one being frankly oriented toward the claimant and the other against him. Then each doctor could present the evidence on which he bases his decision. Some kind of compromise could then be reached which would hit nearer the truth than accepting the opinion of a tribunal, when that opinion is so easily influenced by one doctor's personality.

Some doctors suffer from racial or religious prejudice, and allow this to influence their judgment. I know a southern psychiatrist who says that it is normal for a Negro to have hallucinations when he is emotionally involved, particularly in a religious setting. The same doctor added that this would be pathologic in a white man. He failed to see that the hallucinatory experience was related to culture, not to color. For a well-educated, sophisticated, urban Negro this kind of experience is just as pathologic as it is for a white man in the same setting. But my colleague had a very deep-seated prejudice which made it impossible for him to consider Negroes as of the same cultural level as white people. His diagnosis was materially influenced by his prejudice. It would be wonderful if every doctor could be innocent of every prejudice. However, the doctor is likely to have some prejudices, and the next best thing is for him to recognize that fact, and affix a kind of addendum to any diagnosis in this area indicating that he knew that he wasn't entirely free of prejudice.

We also see this with respect to alcohol and smoking. Alcohol is a helpful medication in peripheral vascular disease, and in certain

types of coronary disease. Nonetheless, I know doctors who, for moralistic reasons, will not accept this. They forbid their patients to use alcohol which, they say, is an unmitigated evil. It is also true that doctors who drink too much rationalize their drinking on the grounds that alcohol is a wonderful vasodilator or a wonderful tranquilizer, and that in drinking, they are merely practicing good medicine on themselves. Such practitioners cannot give an opinion on this general subject without being personally involved. And here, too, as with other prejudices, we must face the fact that the prejudices exist, rather than try to pretend that the doctor is being one hundred per cent objective. Today, you can get into a hot argument about the tranquilizing drugs. Some believe that the tranquilizers are a great boon. They say that, given enough tranquilizers, people will lose their hostile impulses, and thus we will see a reduction in crimes, strikes, and wars, because everybody will be relaxed. There are others who think that the tranquilizers lull us into false security, and rob us of the divine spark of discontent without which there can be no art and no progress. Some doctors articulate these philosophies, but most of us don't articulate them, we merely practice them. According to our particular bias or philosophy, we will make judgments concerning the tranquilizing drugs.

Controversy is now raging about cancer of the lungs and the smoking of cigarettes. If a bridge were considered unsafe on one-tenth the evidence which now condemns cigarette smoking, the bridge would long ago have been closed to traffic. Yet there has been no drop in the sale of cigarettes, even though the evidence is as strong as it is. Some doctors explain this on rather flippant grounds, as for example by saying that "you've got to die some time." Others say with equal flippancy that the experimental evidence now proves only that mice should not smoke cigarettes. Generally speaking, the doctors who are unwilling to accept the connection are heavy smokers themselves. Here again, the doctor's prejudices cloud the scientific evidence.

I do not accuse anybody of being bigoted. I merely point out that having a prejudice, or if you want to use a less critical term, having a crotchet, is part of being human. Instead of calling them prejudices or crotchets, we could just say that this is part of your personality. Just as one person is cheerful and another is gloomy, so one person has strong feelings about smoking or about different racial groups, and another one doesn't.

Perhaps there is something of value in these differences. We would shudder at a civilization where there was a single medical doctrine to which all doctors had to agree. I suppose that in Russia or in similar dictatorships, if the high command decides that all peptic ulcers should be operated on, or all hemorrhoids should be injected, then this becomes the official doctrine, and heaven help the doctor who deviates from it. If we allow professional freedom, then there comes with it the freedom to have all kinds of whims and peculiar ideas colored by our own personality, rather than drawn out of scientific facts.

THE BEDSIDE MANNER

THERE are doctors who can make a patient feel better simply by walking into the room. This magic seems to be totally unrelated to the doctor's education, or even to his intelligence. Take your old medical school yearbook and list the two or three least intelligent and least knowledgeable members of your class. Then list the two or three with the highest I. Q. and the most medical knowledge. Do a little follow-up study, and you will find that there is no relationship at all between the student's class standing and his subsequent success as a physician. The success of the cults should convince us that there is a lot more to the art of healing than medical knowledge. Certainly the major factor in this additional skill comes under the heading of the healer's personality.

The physician can usually remain outside the patient's problem when that problem is physical illness. If the doctor happens to have diabetes, he cannot remain objective about the patient's diabetes. But unless he happens to suffer from the patient's affliction, the physi-

cian can comfortably look at the patient's anemia, constipation, or eczema without getting too deeply involved himself. It is quite different with emotional disorders. The patient's problem may be rooted in a marital difficulty, a sibling rivalry, or in the difficulties of being a wise parent. The doctor himself has such problems. Like the patient, he too may have a sense of inadequacy or of over-confidence; he may have sexual impotence himself, or he may be subject to anxieties, tensions, and compulsions. Thus when the patient's symptoms or diagnosis fall into the category of emotional illness, or emotional components of organic illness, the doctor cannot be nearly so objective. This is another way of saying that while not everyone has had diverticulosis or hypertension, everyone does have personal emotional problems. So, in this area, the physician's own personality is indeed an invisible but built-in part of the prescription he gives the patient.

In contemporary medicine, there is a tendency to demand that the patient make the decisions. For example, you tell the patient that he has a hernia, and you say he can leave it alone, get injections, wear a truss, or have a herniotomy. You spell out the pros and cons, and sit back for the patient's decision. You may be proud of your indecisiveness, arguing that you are being democratic. But one of the things that the patient is paying the doctor for, is to make decisions. When a man is sick, he doesn't want the added burden of making important decisions. And this is where the doctor comes in. The physician who is capable of making crisp and fast decisions is a better and more effective doctor than the one who, under the guise of democracy, evades his responsibility, and forces on the sick and anxious patient the additional burden of making decisions. In making this statement I confess I am influenced by my own prejudices.

It is all very well to be friends with your patients, but a doctor-patient connection cannot be a buddy relationship. It is a relationship of the sick and the well, of the dependent and the independent, the passive and the active. The buddy system will not work. The use of first-name terms between doctor and patient tends to blur the sharp edge of the relationship, to its own detriment.

I here take the position—admittedly not provable, but based on my own crotchets—that one of the qualities in the doctor's personality that make him effective and successful is decisiveness.

THE doctor's cheerfulness is subject to much dispute. In the face of serious illness, the doctor who goes around slapping backs and assuring everybody that everything will be fine, is obviously a nuisance. On the other hand, where you are faced with the choice of being either gloomy or cheerful, the odds are all in favor of being cheerful. Lies can save lives. Where the prognosis is hopeless, the doctor ought to be cheerful even though this is dishonest. He has to take into his confidence some member of the family, to whom the real prognosis will be given. But it is surely the doctor's first duty to cure, and if he can't cure, his next duty is to do no harm. Under these circumstances, telling the truth may demoralize the patient. It may drive him to suicide, or remove the will to live. At the beginning of my talk, I cited the man whose will to live kept him alive for a few extra days. Now we can look at the reverse of this. A patient who lacks the will to live, or believes he is doomed to die, and therefore feels there is no use struggling—such a person will die quicker. Some of you may doubt this, but the experience of psychiatrists and surgeons alike shows that the patient's will to live, or the patient's giving up in defeat, may make the difference between life and death. If this is so, then the doctor's own cheerfulness becomes a life-giving factor in the doctor-patient relationship.

ACTIVE OR PASSIVE?

WHILE the physician should not generate anxiety in the patient, he might do well to have a capacity for developing some anxiety in himself. At one extreme is the calm, cool and col-

lected practitioner who has no inner tensions or anxieties about the patient at all. At the other extreme is the doctor who dies a thousand deaths whenever the patient gets a pain. Neither of these extremes is any good. The detached physician at the cold end of the spectrum lacks the spark which an effective human relationship requires. And the over-involved doctor at the warm end of the spectrum gets too entangled in his own emotions. This ability to generate anxiety, coupled with the ability to restrain it, is part of the doctor's built-in personality—and this, of course, influences his effectiveness as a therapist.

Somewhat akin to this is the argument about whether the doctor should be relatively passive or relatively active. The answer is that there are two kinds of patients. Most patients want an active doctor, because they would rather be passive and have decisions made for them. There are a small number of patients who want to sit in the driver's seat, and who would be happier with a passive doctor. The rigors of medical school and the competition within private practice are such, that usually the small number of passive people who get into medical school are screened out, or get diverted away from private practice. Thus the population of private practitioners contains a relatively high titre of aggressive and active people. The very activity of the doctor is an inherent part of his personality, and plays a role in his care of the patient.

Sometimes a doctor has so much activity within him that he cannot be passive even when the case doesn't call for activity. For instance, there are doctors who emphasize instrumentation. They are forever inserting cystoscopes, proctoscopes, and colposcopes into any available orifice. They are forever sticking needles into patients, either to put something in or take something out of the body. They put people under electrical machines or in various physiotherapeutic apparatus. They think the patient won't get his money's worth if they just listen and write a prescription or, even better yet, just listen and make some suggestions. You can't blame these doctors, since this is part of their personality. However, excessive instrumentation can lead to trouble. It takes a pretty good doctor to know at what point to interfere with a tool, and at what point to sit on his hands. Too often the decision as to whether to go through a complicated instrumentation is not based on scientific proof of the need, but rather on the doctor's own temperament.

During the last ten years there has been an upsurge of interest in group practice. Many doctors view this with disfavor, because they fear that group practice leads to a dilution of individual responsibility. It tends to make doctors dependent on each other, instead of being completely capable of handling an entire problem themselves. These critics take the position that group practice is a permanent residency. They feel that the patient is fragmented, and has a serious impairment in the loss of his relationship with an individual doctor. Your attitude toward this is a function of your own personality. Up to now, private practice of medicine has always attracted the individualist. This is in line with the American tradition. Salaried hospital work discourages individualism, because the hospital takes total responsibility. Thus, it wants its doctors to prescribe only such drugs as are in the formulary, and wants its doctors to conform to the nomenclature that is printed in their guide book. The doctor practicing entirely within a hospital or clinic framework is not free to do as he wants, because he should always be subject to broad guidelines laid down by the officials.

Similarly with practice in the Army and the Navy, with industrial practice, and with research for foundations or laboratories. All these forms of practice attract men who are willing to surrender some degree of freedom for the other advantages. It follows that private practice consists of disproportionate numbers of doctors who have a bent towards being soloists. This has shaped American medical practice. The individual personality of the solo practitioner has a far greater effect on his patients than the individual or combined personalities of a group of practitioners.

MEDICINE has had a bad press lately. This has generally taken the form of a report that it was hard to get a doctor in emergencies, or that the doctor gives the patient a brush-off, or that you have to wait all afternoon in a doctor's office. Most of these complaints, when investigated, turn out to be unfounded. Nonetheless there is evidence that physicians do not, by and large, hold the affection of the general public that they enjoyed half a century ago. There is exquisite irony in the fact that when the doctor of 1900 had so little medical science in his little black bag—when he couldn't really do much for the patient—he was beloved and respected. Today, he carries a bagful of wonder drugs, and research people have lengthened life and have given the doctor alembics which no emperor could have bought 40 years ago. Now that the physician is more useful than ever, he is less loved.

This is related intimately to the question of the doctor's own personality. Most doctors are busier than they want to be, so that a doctor no longer need be afraid of hurting his patient's feelings, or of losing the patient by shabby treatment. There is always another one if this patient leaves him. Unconsciously this feeling is communicated when you talk to doctors and they speak of the difficulties they have with individual patients. They tend to shrug them off, their attitude being "It's a free country, and if the patient doesn't like the way I treat him, let him get another doctor." Similarly, you see this in connection with working on Sundays and over holidays.

Some years ago when I was in Washington with a Government agency, I sat on a board to determine whether a doctor should be reprimanded, or even discharged, for neglect. What happened was this: he was about to sit down for lunch in his hospital, when word came that one of the attendants in the kitchen had fainted. The doctor went into the kitchen and found this attendant on the floor, gasping for breath. He examined him, realized that he had had a heart attack, turned around and said to the chef: "Get a stretcher and have him littered into the employees' ward. Meanwhile, call up and have oxygen set up in the ward. Here is some medication to be given immediately." The doctor handed the paper to the dietician, left the patient on the floor, and returned to the dining room. The doctor finished his lunch. The patient died before the litter could get there.

The superintendent of the hospital was very angry and preferred formal charges. The doctor was righteously indignant at this implication of neglect, and pointed out that even if he had sat there holding the patient's hand, he wouldn't have prolonged his life by one second. He also explained that, in scientific terms, the doctor did everything that could be done.

This was true. The physician did everything that could be done—in scientific terms. Where he failed was in human terms. The incident made the kitchen personnel feel that the physician was being snooty. One of them actually said: "I'll bet if this were another doctor or a social worker who had collapsed like that, the doctor wouldn't have walked out and callously eaten his lunch." This indictment is not true, but the experience gave the kitchen personnel a feeling that they (the kitchen people) were being viewed with contempt.

I questioned the physician myself: "Don't you think it looked callous of you to finish your lunch while the poor man was dying?" The doctor simply did not know what I was talking about. He said to me: "But nothing I could have done would have made one bit of difference. You don't really think that you or I or any other physician had any magic remedy for saving that man's life, do you?" I agreed that none of us could have done a thing. "Well," he said, "if none of us could have done anything, why shouldn't I have gone ahead and had my lunch?" I could never get into his head the idea that it just looked bad, because traditionally the physician is supposed to stand by. It would have done the doctor no harm to stand by, figuratively holding the patient's hand until either he had died or help had come.

This is the kind of thing I mean when I say that the doctor's own personality plays a role in the public's affection or cynicism.

The relationship between consultant and

general practitioner depends more on the relative personalities of the two physicians than it does on the scientific issue. In the American system, it tends to be a colleague or brother relationship. In Europe, notably in Britain, it looks more like a teacher-pupil relationship. Some family doctors are so constituted that they become hurt when the relatives want a consultation. Occasionally they say so. More often they just look and act offended. What complicates matters is that in a large proportion of cases, the consultation contributes nothing to the actual care of the patient, however much it may contribute to the relative's peace of mind. Many general practitioners construe the need for a consultant as a confession of inadequacy. If the family doctor falls into this category, his tendency is to be hostile to or critical of the specialist, particularly to other doctors, sometimes even to the family. If good patient care requires the advice of the specialist, then the doctor's personality may significantly shape the quality of that care.

DOCTORS CAN HAVE CROTCHETS

So far, I have dealt with the normal variations in the personality of the doctor, and how this affects both the diagnosis and the treatment of patients. Let me mention briefly some of the abnormal personality traits. I give this only brief mention, because by and large doctors are a fairly stable and emotionally healthy lot. Very few doctors come to mental hospitals as patients. This is an interesting phenomenon. Some of the private hospitals do have among their mental patients a few physicians, but the ratio is considerably below the figure for movie actors, advertising executives, and school teachers. Generally speaking, the mental health record of the medical profession is very good.

Nonetheless, there will always be some crackpots in any profession, and with 200,000 doctors of medicine in the United States, it is inevitable that there must be some peculiar people among them. In fact, I'm sure you know a few of them.

One of the most dramatic of the personality oddities to entangle itself in medical practice is the obsessional neurosis. You know the kind of doctor who believes that one condition can explain many diseases. There is no sharp line between a doctor who merely happens to have an unusual interest in something, and the doctor who has an absolute obsession on the subject. I know a physician who believes that arthritis is related to the eating of high-fat foods. Every time he gets a patient with arthritis, he puts him on a low-fat diet. He makes the diagnosis of arthritis in many cases where nobody else can see any joint involvement.

I knew another doctor—this takes us back to the 1930s—who believed that focal infection was the cause of allergic phenomena. He was obsessed with the idea that the culprit was the colon bacillus, and he persuaded many surgeons to perform, and many patients to submit to, surgical removal of the descending colon. At first we took this as a joke, and we used to say that he was converting the colons into semi-colons. But it got to be no joke, and after a while he was forced out of practice. Now he is a very old man who still believes that he was on the right track, and that he was the victim of a group of narrowminded colleagues.

Of course, anybody who has an obsession can take refuge in the fact that they once laughed at Christopher Columbus. Certainly there are good ideas in medicine that at one time were thought to be foolish. However, it is surprising how few such ideas there are. This complaint of the obsessional doctor does not seem to be well founded. It is true that occasionally you might prevent an advance in medical science if you refuse to give the obsessional doctor a chance to air his obsession, but this does not happen very often.

Then there are, believe it or not, hypochondriacal doctors. This is an interesting phenomenon, and some day somebody ought to write a paper on the doctor as a hypochondriac. The hypochondriacal doctor makes a special impact on his patients. We laugh at the cartoon in which the patient complains of backache, and the doctor says: "You think *you've* got an aching back? Wait till I tell

you about mine!" However, there are actually doctors like this. This morbid overconcern with their own organs interferes with their ability to treat patients. I have even heard this defended on the grounds that it makes the doctor more human, and makes the patient identify with the physician. However, in actual truth, the patient's attitude toward the sick doctor is like that of the observer toward the shoemaker whose children run barefooted, or toward the bald-headed barber. The feeling—admittedly a silly feeling, but nonetheless a real one, is—"If he can't even take care of himself, what good is he going to do me?"

Some doctors have "father" personalities, and they have both the advantages and disadvantages of being a father. They do give a patient the feeling of security, a feeling that everything is all right, a feeling that they understand. Certainly many patients want a doctor to be a fatherly or priestly kind of person. On the other hand, the modern trend in medicine is not toward the "father" but toward the "brother" personality. The newer theory is that you should take the patient into your confidence, show him pictures in the medical books, let him read the laboratory reports, and explain what you are giving him in a prescription. The thesis is that this not only flatters the patient, but also that by taking the magic and mystery out of medicine, you are being more scientific. To the doctor who is a natural "father" person, this is a difficult approach. He is better off doing what he wants to do—that is, to take the position: "I am the doctor and you do what I say, or else." On the other hand, if you do not have the temperament that can say this and get away with it, you are better off sticking to your own personality. In a free economy like ours, the patients sort themselves out according to the kind of doctor they want—or according to the kind of doctor they deserve. The passive sort of patient, who really needs a father to tell him what to do, will feel uncomfortable with the "buddy" kind of doctor, and drift into the office of a more fatherly physician. Conversely, the rather dynamic, active, bossy man, who considers the doctor his servant, will soon fall out with an equally aggressive, domineering physician, and he in turn will seek for the more passive type of doctor.

Personalities also determine whether a doctor goes into private practice, whether he stays there, whether he goes into research, or whether he goes into teaching. They also determine the man's status in medical societies, and to a large extent, in hospitals. It would be naive to suppose that a doctor's promotion in a hospital is one hundred per cent a matter of merit and seniority. Personality factors play a very real role. This, in turn, is related to the kind of practice he can do, because often a doctor's status in a hospital, medical school, or medical society hierarchy also has reflections in the development of his practice.

The lucky doctor is the one who, early in his professional life, has discovered his assets and liabilities, and has tried to develop the kind of practice that suits his temperament. The passive, dreamy kind of doctor will find himself ill-suited to certain types of communities, and would be lucky if he discovers this early in life, and changes to some area where these qualities are advantages, rather than doggedly sticking to the kind of practice for which he is unfitted.

I suppose that if I had to summarize my little sermon here, I could do so in two words: "Be yourself."

Essex County Overbrook Hospital

Matthew Molitch, M.D.

Atlantic City

Palliation of Carcinomatosis with Triethylene Thiophosphoramide

Eighty per cent of the patients treated with triethylene thiophosphoramide were helped by it. These were patients with far advanced carcinomatosis developing from ovarian or breast tumors. Though only palliative, this preparation seems to be worth trying in otherwise desperate situations.

Many physicians are faced with the problem of caring for patients with widespread metastases from carcinoma of the breast or ovaries. These patients usually have had surgical, x-ray, and androgen therapies. This is the report of an experience with a few patients which was gratifying to the patients, to their families, and to the treating physicians.

The drug used was triethylene thiophosphoramide.* It is one of a group of alkylating agents which has a cytotoxic effect on the nucleic acid of the nuclei of cells. This tends to prevent the cancer cells from multiplying. The alkylating agents have the ability to introduce an alkyl group into a compound, and others than triethylene thiophosphoramide are the well-known nitrogen mustard, TEM, the phosphoramides and chlorambucil.

The drug was given intravenously in an aqueous solution† containing 10 to 15 milligrams per cubic centimeter. It was given in courses of five injections each, one every other day, with an interval of three weeks between courses. Since the drug depresses bone marrow, complete blood counts, including a platelet count, were done prior to starting the treatment and before each course thereafter. Transfusions were given to all patients who already had or who developed an anemia during treatment. White blood cell counts were done before each injection. No injection was given if the count was down to 2000. The drug was stopped until the white blood cell count returned to at least 3000. A drop in platelets was not too alarming if no purpuric spots or bleeding occurred. The drug was stopped if purpuric spots appeared and prednisone prescribed in five milligram doses three or four times a day.

CASE REPORTS

Case 1. A 37-year old housewife had a radical operation on the left breast for carcinoma in 1954. A year later, a metastatic node was removed from the scar. She was then given ten x-ray treatments (3000 roentgens in air). The chest was negative by x-ray for bone or lung pathology. Four months after the completion of the x-ray therapy, she developed pains in her chest and back of such severity that she required narcotics. During the next three months, she was given forty injections of testosterone propionate. An x-ray at this time showed widespread metastases to the vertebrae, with pathologic fractures, and to the ribs. The

*Supplied through the courtesy of Dr. J. M. Ruegsegger of the Medical Research Section of the Lederle Laboratories Division of the American Cyanamid Company.

†The solutions were prepared by dissolving the drug in distilled water and then sterilized by passing through a sterile filter. Thanks are due Mr. Henry Frank, bacteriologist, for preparing the solutions.

patient was wasting away to just skin and bones with inability to turn over in bed without screaming with pain. It was difficult to relieve her even with frequent injections of narcotics. She was hospitalized at this time and a body cast was applied with some relief from pain. She was kept in the hospital because she was considered a terminal case, requiring around-the-clock nursing care. Her anemia was corrected with transfusions.

Triethylene thiophosphoramide became available to me after the patient was in the hospital several months. She was given three courses, and showed remarkable improvement. The white blood count was once down to 1000 and the platelets to 7000. The patient was discharged to her home six months after admission to the hospital. She continued to improve, and x-rays revealed recalcification of the vertebrae and ribs. Now, a year after the first course of injections was given, she is ambulatory, drives her own car, goes to the beauty parlor, and to the movies. She appears a little round-shouldered because of healed compression vertebral fractures. I plan on giving her additional injections of the thiophosphoramide for recurrences of pain.

Case 2. A 45-year old woman had a radical operation for carcinoma of the left breast in April 1956. She received x-ray therapy. Later x-rays revealed metastases to the bones. She was in constant pain and took sedation orally with indifferent relief. Her family physician, Dr. C. Paul Cameron of Somers Point, at the suggestion of the roentgenologist, Dr. Daniel Wilner, asked me to treat her with thiophosphoramide because of the excellent results obtained with case 1.

This patient was given four courses with gratifying results. She has less pain, and x-rays revealed recalcification of bone. After the last course, she developed an anemia which required several transfusions. The patient is anxious to get more treatment because she finds less need for sedation.

Case 3. A 73-year old woman was given four courses of triethylene thiophosphoramide because of extensive metastases involving both lungs. The uterus, bladder, rectum, and vagina were also involved. The primary site was probably uterine. She failed to improve and died four months after the start of therapy.

Case 4. A 65-year old woman was referred by the Tumor Clinic of the Atlantic City Hospital. She had an inoperable carcinoma of the left breast. She had received x-ray therapy. She has metastases to the pleura and a right pleural effusion. She has received five courses of triethylene thiophosphoramide with a marked subjective improvement. She is able to breathe better and to walk up steps. She was recently given a blood transfusion for anemia. X-ray examinations revealed no change in her condition.

Case 5. A 45-year old woman had a mastectomy in March 1957, for a carcinoma of the right breast. She received no x-ray therapy, but she was given testosterone injections. Several months ago, she developed pain in the back, and x-rays revealed metastases to the vertebrae. She became confused mentally with hallucinations. After several transfusions, her family physician, Dr. C. Paul Cameron, who was given a supply of triethylene thiophosphoramide, administered one course of five injections with a decided improvement in her condition both mentally and physically. It may be that her mental condition improved because of the decrease in the use of drugs. At the time of the writing of this report, she was starting a second course.

In 1953, Shay *et al.*,[1] while experimenting with triethylene thiophosphoramide in the treatment of leukemia, noted its tumor inhibiting effect on two patients, with recurrent and metastatic adenocarcinoma of the breast. They studied this nitrogen mustard-like drug and found that it could be administered intramuscularly, intravenously, or locally into tumor nodules without any immediate untoward effects such as nausea, vomiting, or anorexia. There were no local toxic reactions and none on the liver. The only toxic effects were bone marrow depression, especially in those with bone metastasis, and a peripheral leukopenia. The amount of drug necessary to depress the bone marrow varies from patient to patient. Not all patients who are benefited get bone marrow depression since less of the drug is required to get beneficial effects than to cause toxic effects.

They reported on 47 patients, and found that the drug had carcinolytic properties in patients with inoperable and far advanced and disseminated carcinoma of the breast or ovary. No benefits were found in patients with other malignancies or in organs other than the breasts or ovaries. They also reported that roentgen ray therapy to local lesions can be given at the same time but with caution since triethylene thiophosphoramide is a radiomimetic substance. Some patients show no initial response and some become resistant and new metastases occur in spite of continued treatment. They used the drug in ten milligram doses and withheld it if the white blood cell count was below 3500, if the platelets were below 150,000, and if the hemoglobin and red

1. Shay, H., and Sun, D. C. H.: *Cancer*, 8:498 (June, 1955).

blood cell count were low. Maintenance therapy included transfusions and antibiotics.

Bateman *et al.*,[2] reported on 122 cases of mammary carcinoma, ranging in age between 26 and 85 years, and found that 81 of them were improved. They used the drug intravenously in ten milligram doses, and in larger doses directly into tumor sites, intrapleurally and intraperitoneally. They recommended the withdrawal of the fluid, in pleural effusion, before injecting the drug. They noted that the length of time between the onset of the disease and the start of drug treatment was immaterial. Improvement was noted in ulceration, tumors of breasts, metastatic nodules and nodes, inflammatory spread, facial edema, hydrothorax, pericardial effusion, ascites, osseous metastases, pulmonary metastases, central nervous system involvement, and hepatic metastases.

BATEMAN and his colleagues [2] noted no side effects but did report bone marrow depression. Antibiotics were not given even when the white blood cell count was as low as 2000 if no clinical signs of infection were present. Transfusions were given when the hemoglobin was down to about seven or eight Grams. Cortisone in doses of 25 milligrams was given when hematopoietic depression occurred with general debility. They recommended that patients who are not moribund and in whom a life span of at least six to eight weeks can be anticipated should be treated with triethylene thiophosphoramide.

Bateman and Winship [3] reported on 22 patients suffering from ovarian carcinoma. These patients were treated for from one to twenty-two months and given between 110 and 780 milligrams of the thiophosphoramide or an average of 353 milligrams. The drug was given intravenously, intrapleurally, intraperitoneally, intracardially, transvaginally, transabdominally and into the tumor. Most of the patients received objective improvement with the regression of tumor masses, control of pleural, pericardial, and peritoneal effusions. The therapy is palliative only. It must be continued since it keeps patients alive for months.

Cooper [4] with an experience with several hundred patients suffering with advanced breast and ovarian carcinomatosis found that 40 per cent were improved and freed from pain. Eight per cent had really excellent results. He treated ascites and pleural effusion by injecting, intrapleurally and intra-abdominally, 50 to 100 milligrams of triethylene thiophosphoramide in one dose. He found it to be superior to radioactive gold. Cooper [4] also injected the same dose into the site of pathologic fractures. He treated chorionepithelioma intravenously with encouraging results. He got better results in leukemias and lymphomas with other drugs. Ravdin [5] reported that his group has been unable to verify results obtained by Bateman [3] and others,[2] and that only about 10 per cent of the patients have been improved. He also stated that more encouraging results have been obtained with alternating courses of androgens and estrogens in these far advanced cases. His group is now working with carcinogens, chemicals which have produced carcinomas in animals and which are being found to alleviate symptoms and to prolong the life of patients with far advanced carcinoma.

SUMMARY AND CONCLUSIONS

1. Triethylene thiophosphoramide is an alkylating agent which tends to prevent cancer cells from multiplying. It is palliative in far advanced carcinomatoses originating from the breasts or ovaries. It seems to work best when injected in 50 to 100 milligram doses directly into tumor masses. It may be used intramuscularly, intravenously, intrapleurally, and intraperitoneally. It is used after everything else

2. Bateman, J. C. and Carlton, H. N.: Journal of the American Medical Association, 162:701 (Oct. 20, 1956).

3. Bateman, J. C. and Winship, T.: Surgery, Gynecology and Obstetrics, 120:347 (March 1956).

4. Dr. William M. Cooper, University of Pittsburgh School of Medicine in a personal communication, September 18, 1957, while "Visiting Chief" at the Atlantic City Hospital.

5. Dr. I. S. Ravdin, University of Pennsylvania School of Medicine, November 25, 1957, while "Visiting Chief" at the Atlantic City Hospital.

has been tried, including surgery and x-ray therapy.

2. Triethylene thiophosphoramide relieves pain, recalcifies bones, decreases ascites and pleural effusions. Ulcerations improve and inflammatory spread is inhibited. It has been found useful in central nervous system involvements and hepatic metastases. No local reactions have been reported, but the drug does depress the bone marrow. Stopping the drug allows the bone marrow to recover. If severe anemia occurs, transfusions are given. Beneficial results are obtained in most cases without toxic effects.

3. It is used for palliation only. It is suitable for use in a doctor's office or in the patient's home. The only precautionary measure advised is to take a complete blood and platelet count before starting treatment and between courses. A white blood count alone is done before each injection.

4. Four of the five patients reported have improved and one is alive and active one year after treatment.

ADDENDUM

Since this article was written in November, 1957, the patients in case reports 1, 4, and 5 died. The patient in case 2 has escaped from the beneficial effects of the drug and the carcinomatosis has spread. In most of the cases, the patients' lives have been prolonged with less suffering and less dependency on narcotics. The patients were impressed by the fact that efforts were being made continuously in their behalf.

705 Pacific Avenue

Medico-Legal Society of New Jersey

Legal cases involving personal injuries require, for just disposition, the cooperative efforts of both doctors and lawyers. This applies both to proceedings in the regular courts and to actions before the Workmen's Compensation Bureau. Cooperative effort between doctors and lawyers is also needed in civil and criminal cases involving problems created by psychoses, epilepsy, or head injuries. To obtain justice for the public, both doctors and lawyers must not only understand the technics and principles which govern their professions in these matters, but they must be trained to cooperate with each other.

With this in mind, the Medico-Legal Society of New Jersey was formed two years ago to cultivate better understanding between the two professions, and to help both groups fulfill their obligations to the community in the administration of justice.

Since 1956, many interesting meetings on medico-legal subjects have been held by the Society, first under the presidency of Honorable Reynier J. Wortendyke, Jr., of the United States District Court and next under the presidency of Dr. Henry A. Davidson, Medical Director of the Essex County Hospital at Cedar Grove. Present officers of the Society are: *President,* Honorable Richard Hartshorne, of the United States District Court; *President-elect,* Dr. Henry A. Brodkin; *Treasurer,* Frederick B. Lacey, Esq.; *Secretary,* Dr. Frederick S. Barnes, 786 Parker St., Newark; Trustees are Milton A. Schreiber, Esq., Dr. Edwin Albano, Dr. A. Russell Sherman and Stephen Lorenz, Esq.

Several meetings of particular interest to both the legal and the medical professions have now been scheduled for the 1958-59 program of the Society. All readers of this JOURNAL are welcome to attend these interesting and informative sessions. Professional personnel who desire to obtain more benefit from the active work of the Society, may obtain data as to membership by writing to Secretary, Dr. Frederick S. Barnes, 686 Parker Street, Newark, N. J. The next meeting, October 15, is announced on page 518 of this JOURNAL.

Louis L. Perkel, M.D.

Jersey City

Ulcerative Colitis - A Review of Its Etiology, Diagnosis and Management*

One of the most mysterious and most devastating of gastro-intestinal disorders is ulcerative colitis. In this brief monograph Dr. Perkel reviews the medical, surgical, and psychiatric aspects of this disorder.

Non-specific ulcerative colitis is an inflammatory disease of part or all of the colon characterized by rectal discharges containing mucus, pus and blood. It is usually accompanied by frequency of defecation, cramping abdominal pain, constitutional manifestations, and numerous colonic and extracolonic complications. The disease is not hereditary, epidemic or infective. It is a serious disease of deep concern not only to the patient and his family, but also to the attending physician.

Some synonyms of non-specific ulcerative colitis are: idiopathic, indeterminate and primary ulcerative colitis; colitis gravis; thrombo-ulcerative colitis; and distal ulcerative colitis. The latter designation comes from the fact that 90 to 95 per cent of cases begin in the lower rectum and extend proximally. The remaining 5 to 10 per cent are proximal to the rectum and are called regional or segmental colitis. When confined to the right colon, they are termed *right-sided colitis*. Spastic colitis and mucous colitis are functional conditions incorrectly named. They should be known as spastic colon, or preferably, irritable colon.

The incidence of ulcerative colitis in the general population is low. The large series of reported cases are from large hospitals, and represent from two to nine cases per thousand hospital admissions. The incidence is about equal in both sexes. It most commonly occurs between the ages of 20 and 40. It occasionally is seen in the very young and rarely in the aged. The disease is apparently less common in warm climates. It is infrequent in Negroes.

ETIOLOGY

Discovery of the cause of ulcerative colitis is hampered by many factors. The disease does not occur spontaneously in animals, nor can it be convincingly reproduced in them. Further, the disease runs an unpredictable course with spontaneous and unexplained remissions, making it difficult to evaluate therapeutic results that might give a clue to the etiology. Some of the commonly associated symptoms, such as weight loss, anemia and vitamin and protein deficiency, may color the symptomatology and even aggravate the pathologic changes in the colon. We are not sure whether ulcerative colitis is a single disease or

*Read before the Alpha Omega Alpha Annual Symposium at the State University of New York, College of Medicine at New York City, January 30, 1958.

a group of allied disorders. We are also in the dark concerning the relationship of the distal to the segmental form, as well as the relationship between ulcerative colitis, regional enteritis and so-called ileo-colitis. Nor do we know why the ileum is involved in about 25 per cent of cases of ulcerative colitis, nor why the colon is involved in about 15 per cent of cases of regional enteritis.

The theory that *infection* is the cause seems plausible, especially when one views the inflamed, ulcerated mucosa through the proctoscope and notes the clinical findings of toxemia and fever. Yet there is no proof that infection is the initiating cause. The bacterial count in the stool of ulcerative colitis patients is 50 times more than in the normal person. Sulfonamides are able to bring temporary reduction in the bacterial count. But the scant permanent improvement rules out bacteria as the primary cause.

HURST,[1] in 1921, proposed that ulcerative colitis might be a chronic form of bacillary dysentery. Felsen and Wolarsky,[2] in their study of the 1934 Jersey City epidemic of bacillary dysentery, found a few cases, followed one year after the epidemic, that manifested some signs and symptoms of ulcerative colitis. But the evidence is insufficient to indict the dysentery bacillus as the cause of ulcerative colitis.

Bargen,[3] in 1924, asserted that the diplostreptococcus was the cause of what he termed thrombo-ulcerative colitis. Most investigators, notably Paulson,[4] challenge its specificity and believe that this and other organisms are probably secondary invaders. Other bacteria, viral agents and fungi have also been incriminated, but none proved. Lymphopathia venereum bears a superficial clinical resemblance to ulcerative colitis but is not considered an etiologic factor.

Although occasional diffuse inflammation of the colon has been observed following recovery from amebic dysentery, the Entameba histolytica has not been shown to be the cause of non-specific ulcerative colitis. Since 5 to 10 per cent of healthy people are carriers of this parasite, its discovery in the stool does not prove that it is the cause of the colitis.

Some observers say that lysozyme, also found in human tears, gastric juice and other secretions, is the cause of ulcerative colitis, through its mucolytic action. The theory is that it destroys the protective barrier (mucus) and allows the bacteria to attack the colonic mucosa. And, indeed, lysozyme secretion increases up to 20 times in ulcerative colitis (in proportion to the severity of the disease) and decreases as the disease process recedes. This hypersecretion may well represent a tissue response to injury. The enzyme is probably derived from the leukocytes in pus and is therefore more likely a secondary factor rather than a primary one. This is shown by the inhibition of lysozyme secretion with a detergent (Aerosol OT) resulting in a prompt fall in the titer, but no alteration in the disease course.

Some have believed that vitamin and nutritional deficiency is the primary cause. However, the avitaminosis and hypoproteinemia, resulting from the anorexia and poor absorption characteristically found in colitis, actually follow and aggravate the ulcerative colitis rather than initiating it.

Andresen,[5] in 1925, suggested that allergy was an important factor in ulcerative colitis. Later,[6] in 1941, he reported that one-third of the patients with ulcerative colitis showed food allergy and were relieved by dietary allergic treatment. In 80 per cent of these, milk was the allergen. Other allergens were wheat, eggs, potato, orange, and tomato. Rowe[7] and a few others support this theory, but most observers do not. Since 10 per cent of normal people have allergy, it is not surprising that some patients with ulcerative colitis should have allergic symptoms. Ulcerative colitis may be considered a systemic disease with sensitization or hyper-reactivity in the colon, perhaps genetically conditioned.

HYPERACTIVITY of the parasympathetic nervous system has been considered by some to be an important etiologic factor. Storsteen *et al.*[8] studied the myenteric (Auerbach) plexuses in colons removed from colitis patients at operation or necropsy, and found in them

3 times the normal number of ganglion cells. Inasmuch as hyperactivity of the vagus causes increased tone and spasm, hypermotility, and an increase of lysozyme output (conditions found in colitis), these observers reasoned that this increased number of ganglion cells was proof of vagus overactivity in colitis. Use of atropin and related anticholinergic drugs (as well as vagotomy) is based on this assumption. In practice these drugs usually do allay spasm and relieve the cramping pain. However, hyperactivity of the parasympathetic (vagus) also occurs in irritable colon a functional condition.

Levine *et al.*[9] noted an absence of homogeneous ground substance in the basement membrane of epithelial cells in specimens of colons removed at operation and necropsy. They believed that this causes the epithelial cells to slough away from the submucosal connective tissue, allowing secondary bacterial invasion. There has been no support for this theory.

Murray,[10] in 1930, and Sullivan and Chandler,[11] in 1932, called attention to psychogenic factors in ulcerative colitis. Grace, Wolf and Wolff,[12] describe experiments on fistulous patients in whom segments of colon were exposed. They found that sustained anger, anxiety, resentment, and hostility, caused hyperfunction of the colon as manifested by hyperemia, spasm, hypermotility, hypersecretion of lysozyme, increased vascularity, and subsequently increased fragility of the mucosa with submucosal hemorrhages, mucosal erosions, and eventually ulceration. They concluded that although the ulcerative colitis patient may be calm outwardly, he is seething inwardly, sitting on a powder keg of intense hostility and resentment.

Psychiatrists have attributed a specific personality to the ulcerative colitis patient. They describe him as an intelligent, fastidious, ambitious, immature, dependent individual, unable to tolerate frustration and disappointment and notably unsuccessful in his ventures. This personality profile is also found in non-colitis patients, and some colitis patients do not conform to this pattern. Nevertheless, emotional factors are of paramount importance in their ability to aggravate the colitis once it is established or to bring on an exacerbation during a remission.

CLINICAL PICTURE

The diagnosis of ulcerative colitis is established on the basis of the clinical picture, the proctosigmoidoscopic findings, the barium enema findings and the absence of specific pathogenic bacteria or parasites.

The disease may manifest itself in three forms, the mild, the fulminating and the intermediate, with occasional transition of one form to another.

The *mild* form constitutes about 50 per cent of all cases. Onset is usually insidious. There may be 2 to 7 bowel movements a day, often with mucus and occasionally with blood. Sometimes there are periods of constipation. Appetite and nutrition are fairly good. There may be slight abdominal cramps, but there are no constitutional manifestations or complications. Usually, the rectum alone, or together with the sigmoid, is involved. Liver function studies and other biochemical tests usually reveal normal findings.

The *fulminating* form occurs in 5 to 10 per cent of cases. This may be the initial manifestation, or it may occur during the course of the mild or intermediate forms. Onset is usually sudden. When fully developed, there is high fever, tachycardia, marked toxemia and prostration and 10 to 30 sanguino-purulent stools in 24 hours. Moderate to severe abdominal cramps, and abdominal distention occur. There may also occur moderate to severe hemorrhage with pronounced anemia, hepatic damage, leucocytosis and rapid sedimentation rate. In these cases, mortality may reach 50 per cent. Death may occur from shock, hemorrhage, perforation or exhaustion due to toxemia.

The *intermediate* form, occurring in about 40 per cent of cases, may pursue an almost continuous course or an intermittent course with unexplained exacerbations and remis-

sions. Exacerbations may follow an acute illness, operation or emotional shock. The symptoms are intermediate between the mild and fulminating forms. The patient is usually in poor nutritional state, has little or no toxemia or prostration, but may have general weakness. He may have fever, tachycardia and moderate anemia. The patient usually complains of abdominal cramps, from occasional and mild to frequent and severe. The colon usually shows extensive changes, as demonstrated by proctosigmoidoscopic and barium enema examinations.

COMPLICATIONS

COMPLICATIONS, which may be colonic or extra-colonic, occur in 15 per cent of all patients, usually during the fulminating or intermediate phases, rarely in the mild. Multiple complications are frequently noted.

Colonic complications in the ano-rectal region (noted in about 10 per cent of cases) include peri-anal and peri-rectal abscesses, fissures, fistulas and hemorrhoids. Pseudopolyposis is found in about 10 per cent of cases. These are not adenomatous polyps, although true adenomas may occasionally also be present. Pseudopolyposis represents inflammatory hyperplasia of islands of mucosa between the ulcerated areas, and, by overgrowth, may assume the form of mucosal tags. They are not precancerous but may be a source of chronic irritation. In some instances they have been shown to be reversible on medical treatment.

Acute perforation of the colon occurs in about 2 per cent of cases. Stricture due to fibrosis is found in about 10 per cent. Massive hemorrhage occurs in about 1 per cent.

Carcinoma is often difficult to detect clinically and by barium enema, because its symptoms and signs may merge with those of the ulcerative colitis. This type of carcinoma is highly malignant and may be multicentric. It metastasizes early and widely and usually occurs at an earlier age than in non-colitis cases. The incidence of carcinoma is very much higher in patients with ulcerative colitis than in non-colitis patients, in whom it is less than 1 per cent. Lyons and Garlock[13] found carcinoma developing in 4 per cent of surgically treated cases of colitis. Recently, Banks *et al.*[14] reviewed 700 colitis cases seen in 20 years at the Boston Beth Israel Hospital, and found a 3.7 per cent incidence of carcinoma. The incidence of carcinoma increases with the duration of the colitis. Dennis and Karlson,[15] in 1952, reported a ratio of 20 per cent in patients with ulcerative colitis for over 20 years. Others have reported incidences up to 35 per cent in patients with more than a 10 year history of colitis.

The extracolonic complications include arthritis, erythema nodosum, pyoderma gangrenosa, ulcers of the mouth, iritis, hepatic insufficiency, fatty liver and cirrhosis, renal insufficiency, and phlebitis.

About half of the cases, either in the mild or intermediate group, may be arrested and go into a remission. The clinical course is unpredictable. A few develop the fulminating phase ushered in by rising temperature and pulse, disturbance of hepatic function, elevation of sedimentation rate, bloody diarrhea and signs and symptoms of toxemia.

PROCTOSCOPIC PICTURE

IN THE *acute* stage, the proctoscope reveals a mottled discoloration of the mucosa due to fine petechiae under the mucosal surface, followed by hyperemia and edema. The mucosa appears moist and glistening with excess mucus. After swabbing, the surface appears granular and shows frank bleeding points. Small ulcers, the result of the breaking down of miliary abscesses, may or may not be present at this time.

In the next phase (which may occur weeks or months later) the mucosa becomes beefy red and more edematous with pitted granular appearance and oozing of blood from the surface. Extensive irregular ulceration, due to coalescence of smaller ulcers, is noted. A muco-purulent exudate, which may be adherent to the wall of the bowel, may also be seen. In the very severe, acutely *fulminating* cases the proctoscope is passed with great difficulty.

There may be seen a tenacious membrane with a thick muco-purulent sanguinous discharge, below which is a coarsely granular ulcerating, markedly congested and edematous mucosa. In the *chronic* stage the lumen is narrowed and tubular. The surface has a cartilagenous character, due to fibrosis. Slight edema and congestion are noted. Pseudopolyposis and a purulent discharge may be seen. In the *quiescent* stage, which may last for years, edema and congestion are not seen. There is little exudate, but the narrowed, stiff-walled colon may persist.

BARIUM ENEMA

THE barium enema findings depend on the stage of the disease, the site of involvement, the amount of pathologic change in the wall of the involved area, and the degree of associated bowel irritability. The findings are not always proportionate to the systemic evidences of the disease. In the early stages, there may be no abnormal signs except for spasm due to irritability. There may be noted a slight fine fuzzy marginal outline (best seen on air contrast films) caused by many small ulcerations as well as mucus adherent to the wall. The air contrast film may also show fine pinpoint flecks of barium, representing punctate ulcerations in the mucosa. Occasionally seen in the early case, is the indenture sign of Poppel.[16] This is a deeply scalloped marginal outline due to acute inflammation of the colon. When the process involves the rectum or rectosigmoid only, it may be difficult to make a diagnosis by barium enema. Here, proctosigmoidoscopy is of far superior diagnostic value.

In the full blown case there is usually noted distortion of the mucosal pattern from the normal delicate, fine, filigreed configuration to a grossly irregular, mottled, mosaic-like pattern. The latter results from a combination of active ulceration, mucosal edema, impregnation of mucus and clumps of pus in the wall of the bowel and islands of pseudopolypoid hyperplasia.

Loss of haustral markings and smoothness of outline of the colon is quite characteristic of the later phase of ulcerative colitis. This sign may also be seen in functional disorders of the colon. To be pathognomonic of ulcerative colitis, it must be permanent, present on all films, including the post-evacuation, air contrast, 6 and 24 hour films, and be associated with rigid, non-flexible colonic walls.

In the more advanced cases, there is a decrease in the size of the colon, both a shortening in its length and a narrowing of its lumen. The colonic wall becomes rigid due to fibrosis, resulting in "lead-pipe" colon. The shortening of the colon may be accompanied by a widening—and eventual disappearance—of the angulation of the flexures. Progressive fibrosis may result in areas of increased narrowing of the lumen, which may lead to stricture formation. There also may be hypermotility due to increased irritability, marked induration of the colonic wall, and destruction of the transverse folds, which normally act as a brake on the passage of colonic contents.

Barium enema is the only means of determining the limits of involvement of distal colitis, as well as revealing the presence of regional or segmental lesions. Although the barium enema may also show disease of the terminal ileum, small bowel studies should supplement it to exclude regional enteritis and determine evidence of a deficiency state. In segmental colitis, the lesion is limited to one or more segments proximal to the recto-sigmoid, and usually extends distally.

DIAGNOSIS

THE differential diagnosis must take into consideration several conditions, most of which have specific causes. *Bacillary dysentery* is diagnosed by stool culture for the Shigella group of gram negative bacilli. This is positive early in the disease. Agglutination tests with specific serum become positive, in dilution of 1 to 100, after a few days. *Amebic colitis* is diagnosed by finding the Entameba in the stools. Complement fixation tests are not de-

pendable. The proctoscopic picture is that of discrete, irregular, punched-out ulcers with relatively normal intervening mucosa. A therapeutic test may be advisable in doubtful or suspicious cases.

In *lymphopathia venereum* there is usually a history of venereal infection, stricture of the rectum, active colitis above it, and a positive Frei test. *Tuberculous colitis* is rare and is usually associated with active and advanced pulmonary tuberculosis. The ileocecal region is mainly involved. *Antibiotic colitis*, due to the overgrowth of fungi or staphylococci, resulting from the use of the more versatile antibiotics, may resemble ulcerative colitis, but the cause is usually obvious and easily removed. In *regional enteritis* the proctosigmoidoscopic findings are negative and there are positive radiologic findings in the small intestine. *Carcinoma* and *diverticulitis* should be easily recognized. Rare causes of ulcerating lesions in the colon are *uremic colitis* and *mercurial colitis*.

MEDICAL TREATMENT

MANY so-called "cures" have been advocated and abandoned. They include intracolonic oxygen insufflation, typhoid vaccine, acriflavine enemas, B. coli serum, and dozens of others. Management of ulcerative colitis is primarily a medical problem. Surgery is necessary when medical treatment fails or to meet complications not amenable to medical treatment. The goals of therapy in the mild cases are adequate mental and physical rest, control of emotional problems either by superficial or deep psychotherapy, restoration of bowel function and elimination of infection. In the severe cases and during acute exacerbations, as well as in the fulminating attacks, correction of dehydration and electrolyte imbalance and control of hemorrhage and correction of anemia due to blood loss are additional objectives.

It is essential to treat the whole patient rather than the local lesion. In no condition is it more important to establish a close physician-patient relationship—a friendly rapport—with sympathy and understanding on the part of the physician. Here the art of medicine is just as important as the science. Frequently it is not the medication that helps, but the physician who prescribes it. In most cases, superficial or informal psychotherapy will be sufficient. However, in certain instances the patient should be referred to a psychiatrist for formal treatment.

Supportive treatment includes the correction of nutritional deficiencies, as well as the anemia. The diet should be bland, low residue, high caloric (2500 to 3500 calories), high protein (120 to 150 Grams), with supplements of vitamins and minerals. Dietary planning must take into consideration possible allergy to food —especially milk. Proprietary food supplements such as Meritene® and Sustagen® fortify the caloric and protein intake to make up for the marked loss of protein in the stool in the forms of blood, pus and mucus. To lessen irritation of stools, hydrophilic colloids, such as Metamucil®, Mucilose®, or Konsyl®, are helpful. Kaolin, bismuth or barium sulfate preparations are of questionable value. For the hypochromic anemia, I have found ferrous sulfate the best tolerated form of orally administered iron.

Sedative-antispasmodic medication is often helpful in allaying the underlying emotional tension, anxiety and apprehension. This also relieves the spasm and hypermotility of the colon. The various combinations of belladonna or atropine with barbiturates, particularly Belladenal®, have been found efficacious. Some of the newer anticholinergic drugs, such as Probanthine® and Prantal®, have also been found beneficial. Recently, the tranquilizing drugs, notably meprobamate, have served as excellent substitutes for barbiturates, bromides or chloral hydrate.

To control severe cramps and diarrhea, try deodorized tincture of opium in doses of 5 to 10 minims, repeated every 3 or 4 hours as required. This is greatly appreciated by the patient in bringing him grateful, though temporary, relief. Other narcotics, such as codeine, Demerol®, morphine or its derivatives may be temporarily used, but only if urgently required.

I have abandoned rectal or colonic instillations, enemas or irrigations. These only add to the irritation of the bowel and lead to no permanent beneficial effects.

At various times I have tried almost all of the sufonamides, including sulfaquanidine, sulfasuxidine, sulfathalidine, Neoprontosil®, and, recently, azulfidine.[17] The last-named has been highly praised by Bargen,[18] Morrison,[19] Machella[20] and others. I think it is the best of all the sulfonamides, with sulfathalidine ranking next best. The adult dose of azulfidine is 2 tablets (or 1 Gram) 4 to 6 times a day.

THE versatile antibiotics, such as Aureomycin®, Terramycin® and Achromycin®, may cause secondary inflammation and should therefore be employed cautiously, if at all. In fact, all medication should be used judiciously and discontinued as soon as possible.

With severe diarrhea, up to 5 liters of water and large amounts of electrolytes (sodium, potassium and chlorides) may be lost daily. This may result in shock and renal failure if replacement is inadequate. In severe cases, it is necessary to measure fluid intake and output, and perform daily urinalysis, determinations of hematocrit, serum potassium, sodium chloride, carbon dioxide combining power and urea nitrogen. Continuous parenteral fluid administration may be necessary and it is advisable to give about 500 cubic centimeters more per day than is lost in the stools and vomitus. At the same time, acidosis or alkalosis should be corrected.

Since 1950, when ACTH and the corticosteroids were first used in ulcerative colitis, considerable literature has accumulated, reporting the results of these hormones in hundreds of cases. My conclusions, below listed, are subject to change with newer knowledge, especially in pharmacologic synthesis of more potent steroid analogues manifesting fewer and milder side effects.

ACTH and the corticosteroids are capable of inducing a remission in about 75 per cent of cases. Steroid therapy may be dramatically effective, and even life-saving, in the fulminating phase and during periods of acute exacerbations. In the acute fulminating case, if it fails to initiate a remission, it may improve the patient's condition enough to render surgery safer.

Administration of corticosteroids should be continued to protect the patient against adrenal failure and to maintain control of the ulcerative colitis until clinical evidence of improvement and normal proctoscopic and radiologic findings result. Then the dose should be gradually reduced. Relapses after cessation of hormone therapy are common. Some have given continuous treatment with small maintenance doses of hormones, as in arthritis, and patients have remained in remission for months.

These hormones are not curative. They are valuable adjuncts to and not a substitute for the basic medical regimen. Being potent and potentially dangerous drugs, they should not be used indiscriminately because of their complications and side effects, some of which may be life threatening.

AMONG the more serious complications are: acute perforation of the colon with peritonitis; large undermined longitudinal ulcers in the rectum and colon, without significant fibrosis; massive gastro-intestinal hemorrhage; and recurrence or formation of peptic ulcer, with occasional perforation or hemorrhage. The steroids may also increase susceptibility to infection. Other side effects that may be noted are certain signs of hypercortinism, such as moon face (Cushing facies), edema (due to sodium retention), hypertension, diabetes, acne, and hirsutism. There may also occur hypokalemic alkalosis, anorexia or voracious appetite, euphoria or depression, and, rarely, psychosis. The newer steroid analogues, such as prednisone, prednisolone and later derivatives, are less likely to produce the electrolyte imbalances and other side effects.

Heroic treatment may be needed in the acute toxic or fulminating phase, as shown by high fever, anorexia, nausea, vomiting, abdominal distention, at times leading the physician to suspect diffuse colonic inflammation, necrosis of the bowel wall with peritoneal ir-

ritation and possibly impending perforation. I have given penicillin, 600,000 units, and streptomycin, 0.5 Grams, intramuscularly twice a day, together with 20 to 30 units of ACTH in 5 per cent glucose in water intravenously every day for 7 to 10 days, gradually reducing the dose as clinical improvement occurs. This is followed by 200 milligrams of cortisone or 80 milligrams of prednisone a day (orally) in 4 divided doses for 2 days, gradually tapered down to a maintenance dose of 80 milligrams of cortisone or 30 of prednisone after 10 to 12 days. Occasionally, I have used ACTH gel intramuscularly, but have found the aqueous solution given intravenously more efficacious.

If the patient shows no improvement on this regimen, surgery is advised. Best results are obtained when the surgical consultant observes the patient with the internist throughout this trial with medical treatment.

Blood transfusions may be life-saving in massive hemorrhage and severe anemia due to blood loss. Adequate blood replacement is essential, particularly in dehydration, in which state natural restoration of blood volume is much slower and early shock more likely. Blood should be typed and cross-matched immediately. Enough blood must be given to maintain blood volume and to prevent shock. The patient should have close clinical observation, with frequent recording of pulse and blood pressure, together with blood volume determinations, if available. A simple guide is the urinary output, which should be maintained at a level exceeding 1000 cubic centimeters per 24 hours. If blood cannot be adequately replaced, or if the bleeding continues, immediate colectomy may be mandatory. Adequate blood transfusions are also helpful in overcoming the toxemia, as well as in correcting the hypoproteinemia.

SURGICAL TREATMENT

Surgery is required for 10 to 15 per cent of patients with ulcerative colitis. The ratio is higher for hospitalized patients because they usually have more advanced lesions than the ambulatory office patients. Wheelock and Warren,[22] recommend colectomy and permanent ileostomy after 2 or 3 years of medical treatment for all ulcerative colitis patients, unless proctoscopic and barium enema examinations showed that the changes are reversible. Few agree with this radical view. In mild cases, cure by surgery may be worse than the disease. In severe intractable cases, particularly with complications and semi-invalidism, surgery is definitely the preferred treatment.

Surgery is indicated when the following are present: the acute fulminating type of colitis, which is not responding to adequate medical treatment; impending or actual acute perforation of the colon; profuse or recurrent massive hemorrhage from the bowel; polyposis, especially the true adenomatous type; (although pseudopolyposis can regress, its presence for a long period of time would indicate a severe chronic form of the disease with chronic irritation, which is probably best treated surgically); carcinoma, either proved or strongly suspected; stricture with obstruction; extensive peri-rectal infection or fistula formation; and intractability with semi-invalidism.

The original procedure in the surgical treatment of ulcerative colitis was ileostomy, ostensibly for the purpose of diverting the fecal stream and putting the colon at rest. Although with ileostomy alone the patient may enjoy temporary improvement, this procedure has proved unsatisfactory. With the colon *in situ*, the patient retains an extensively diseased and functionless organ, serving as a potent focus of infection liable to the many serious complications, including the higher incidence of carcinoma. Subtotal colectomy was then done with or subsequent to the ileostomy, leaving the rectum intact. In most instances (except in the segmental type where the rectum is not involved) subsequent proctectomy was necessary. Attempts at ileo-proctostomy have generally failed to produce satisfactory results, although Aylett[23] recommends this operation in selected cases.

The modern trend is to one stage total colectomy, including the rectum and, of course, a permanent ileostomy. In recent years the advances in surgical technic, anesthesia and control of infection have made surgery much safer. Improvements in ileostomy appliances, together with the education and morale boosting of patients, particularly through ileostomy clubs, have removed much of the terror and stigma of an ileostomy. Almost all patients become well adjusted and satisfactorily carry on practically all of life's activities.

SUMMARY AND CONCLUSIONS

1. Although the cause of ulcerative colitis is not known, advances have been made in its medical and surgical management.

2. The diagnosis of ulcerative colitis is made on the basis of the clinical, proctosigmoidoscopic and barium enema findings, and the absence of specific pathogenic bacteria or parasites.

3. The disease is primarily treated by medical measures, including a bland, high caloric, high protein diet supplemented with vitamins and minerals; the sulfonamides, preferably azulfidine; sedative-antispasmodic medication; psychotherapy; and, if necessary, supplemented by carefully controlled steroid therapy, fluid and blood replacement and correction of electrolyte imbalance.

4. Surgery, preferably one stage total colectomy (including the rectum) with permanent ileostomy, is indicated when medical management fails and for complications not amenable to medical treatment.

5. In severe cases and in acute fulminating attacks, the best interests of the patient will be served by the combined, cooperative management by both the internist and surgeon.

Medical Center

A bibliographic list of 23 citations appears in Dr. Perkel's reprints.

Spicy Suggestions

Good news for patients on sodium-free diets —more than 30 different spices and other foods have been found to brighten the flat taste of salt-free foods and make them palatable. Suggested condiments include: Angostura Aromatic Bitters (used primarily in the preparation of alcoholic drinks), allspice, almond extract, basil, bay leaves, cardamon, carroway, chili powder, cinnamon, clove oil, cocoanut, curry, dill, garlic, ginger, honey, homemade horseradish, jams, lemon juice, lime juice, mace, marjoram, mushrooms, mustard seed, nutmeg, onion, paprika, parsley, freshly ground pepper, peppermint, pimiento, rosemary, saffron, savory, sesame, sugar, tarragon, thyme, vanilla and vinegar.—*American Journal of Nursing*, February, 1958.

Preventive Cardiology

Whether it ever will be possible to reconvert large numbers of "supercivilized" human beings to a greater abstinence from heavy cream, gravy and cigarettes and to the use of their own legs for locomotion "seems questionable," reports Dr. W. Raab, University of Vermont College of Medicine, Burlington. Yet he believes that such a conversion could prevent cardiovascular disease in middle-aged persons. He also urges that "very much more emphasis be placed on rigidly disciplined physical training regardless of the excuse that such practices would be 'undemocratic,' and on a willingness to forego superfluous luxuries and conveniences."—*Journal of the Maine Medical Association*, January, 1958.

Historical Article • • •

Herbert E. Rickenberg, M.A.*

Newark

Development of Frequency Perceived Hearing Tests

Although investigation of the hearing mechanism has been going on since the fifth century, B.C., modern concepts stem from Weber's work as recently as 1825. *In* 1878 *came the first electrically controlled hearing meter—and since then progress has been rapid.*

Historically the perception of acoustic stimuli by an individual has been investigated in two fields (1) physical acoustics, and (2) the psychology of hearing.

The beginning of auditory theory stems from the ancient Greek philosophers who believed that the mind received direct impressions from the outside world. Empedocles in the fifth century B.C. said that sensation always requires an immediate *contact* between object and perceiver. Plato suggested that the tympanic air was implanted during uterine development. Except for Galen in about 175 A.D. further advances in auditory theory remained dormant until 1514 and Carpi's notations of two tympanic ossicles. In 1546 Giovanni Filippo Ingrassia discovered the stapes and apparently initiated the scientific investigation of hearing losses since he also realized that a vibrating tuning fork can be heard when pressed against the teeth.

The scientific investigation of the diagnosis of hearing losses was apparently initiated with Ingrassia's discovery of bone conduction. Ernst Heinrich Weber in 1825 described his tuning fork test, as translated:

> "If both ears are closed by the hands, one's own voice is better heard than with open ears. If one ear is closed, one's own voice is better heard by the closed ear. If a tuning fork is pressed against the teeth and the mouth is closed as firmly as possible and the ears are closed by the fingers, the tuning fork is better heard than with open ears. However, when the meatus of one ear is closed and the other one is open, the sound is stronger heard in the closed than in the open one."

The actual application of Weber's observation to the practice of medicine was fulfilled by Jean Pierre Bonnafont in 1845.

In 1880 Adolf Rinné reported his results in testing hearing by comparing air conduction and bone conduction perceptions by the patient to a tuning fork stimulus. This test was designed to differentiate the location of the lesion: conductive or nerve.

In 1885 Dr. Dagoberth Schwabach published reports of his investigations of 104 cases, asserting that, even though the Weber and Rinné tests are good, they lacked a control. Schwabach examined time heard by the subject as correlated with time heard by the normal hearing examiner.

As the voice is the most universal medium by which our hearing faculty brings us into

*Mr. Rickenberg is Director of the Henry C. Barkhorn Memorial Hearing and Speech Center at the Newark Eye and Ear Infirmary—The United Hospitals of Newark. The Center is named for the late Dr. H. C. Barkhorn who, for many years, was chairman of the Publication Committee which issues this Journal.

contact with our environment it was necessary to formulate a standardized test. In 1870 Oskar Wolf published monographs of the results of investigations for elementary sounds and the maximum distances at which they may be heard by the normal ear. In order to eliminate the possibility of variability in the quality of the voice, actual practice calls for the usage of normal conversational voice and whispered voice.

The development of electrically controlled stimuli was propagated by Politzer in 1877 when he designed the acoumeter in which the sound stimulus resulted from the noise of a small weight falling upon a rigid bar.

One year later, 1878, Hartmann devised the first electronically controlled acoumeter whose output stimulated a telephone receiver. The instrument is described as follows:

> "In the circuit is placed (1) a tuning fork, by which the current is interrupted at regular intervals, (2) a rheocord, or a sliding induction apparatus, by means of which the intensity of the current can be varied at will, and, (3) a telephone, at which is heard a tone corresponding with that of the vibrating tuning fork, of more or less intensity according to the strength of the current."

In 1879 Hughes described an instrument called "induction balance" which he basically used in the analysis of certain metals. He enlarged on the instrument and called it an electric sonometer. Richardson, an otologist of Hughes' time, called the sonometer an "audiometer," In 1882 Ladriet de Lacharriere replaced the sliding induction coil of Hughes to a fixed type using a single electric tuning fork and enclosed the batteries in the same case. There is no record of commercial usage of the instrument. However, there were no basic changes in the audiometer as described by Hughes in 1879 until 1914.

In 1914 Stefanini constructed an electric generator which produced an alternating current with a range of frequencies conducted to a telephone receiver for use in hearing tests.

In 1919 Bunch and Dean collaborated on designing the "pitch range audiometer" which was not produced commercially. This instrument gave impetus to the advent of the vacuum tube audiometer.

In 1921 Minton and Wilson and Guttman described such tube audiometers but none were built.

Finally in 1922, Fowler and Wegel presented the Western Electric 1A audiometer which they had developed. This was the first of the vacuum tube audiometers to be produced commercially. At first the audiogram was charted in per cent. Later this was changed to read directly in terms of sensation units. The Western Electric 2-A audiometer had a frequency range from 64 double vibrations to 8,192 double vibrations in octaves of "C." The Western Electric 3-A audiometer produced a complex noise for rough screening in commercial plants but found little favor among the otologists. The Western Electric 4-A audiometer was designed to present recorded speech stimuli rather than pure tones. It was used extensively as a screening multiple earphone audiometer. The Western Electric 6-A audiometer was introduced in 1936 and utilized electric current rather than a battery and also employed a beat frequency oscillator type of circuit rather than a tuned circuit oscillator.

In 1937 the Maico D-5 audiometer was introduced in which the zero reference level was shifted by automatic mechanical arrangements.

The final advancement in the development of audiometers was in 1947 with the introduction of the automatic continuous presentation audiometer of Georg Von Békésy. This instrument measures the perception of pure tone stimuli from 100 double vibrations through 10,000 double vibrations. Responses of the individual under test are self-recorded by the testee's manipulation of a contact switch which, in turn, controls and varies the intensity of presentation.

77 Central Avenue

Obituaries • • •

DR. PASQUALE CARDINALE

While on vacation in Browns Mills, Dr. Pasquale Cardinale suffered a fatal heart attack and died on August 11, at the age of 59. A native of Croton, N. Y., he was graduated in 1925 from the medical school of the University of Maryland. He interned at the Elizabeth (N.J.) General Hospital and thereafter made that city his home. He was on the staffs of both Alexian Brothers and St. Elizabeth Hospitals. His special field was industrial medicine and he was frequently called to the four corners of the state as a consultant in disability evaluation. He was a member of the Union County Medical Society.

DR. JOHN W. FESSMAN, JR.

Death came on July 28 to Dr. John W. Fessman, Jr., chairman of the Board of the Camden County Hospital for Chest Diseases. Born in Philadelphia in 1904, he was graduated in 1928 from the Hahnemann Medical College in that city. He was active in the affairs of the Camden County Medical Society, a director of the Runnemede branch of the Camden bank, and a former captain in the medical corps of the Army of the United States. During World War II, Dr. Fessman was a surgeon in field hospitals in western Europe. Although he was always proud to be considered a family doctor, Dr. Fessman was especially interested in phthisiology and otolaryngology.

DR. BERTRAM B. KUN

A heart attack on August 7 took the life of Dr. Bertram B. Kun, a Jersey City internist. Born in Hungary in 1902, Dr. Kun was graduated in 1927 from the medical school of the University of Leipzig. He came to the United States in 1936 after graduate work in Germany in internal medicine. He soon became affiliated with the Medical Center, the Christ Hospital and the Fairmount Hospital, all in Jersey City. He was an "attending" in medicine at the Medical Center. He was a major in the medical corps of the Army of the United States during World War II. Dr. Kun was a Fellow of the American College of Cardiology and was active in the affairs of the Hudson County Medical Society.

DR. JOSEPH A. NOVELLO

Dr. Joseph A. Novello, a former member of the Elizabeth Board of Education, died at his home in Millington, N. J., on August 6. Born in Elizabeth in 1905, Dr. Novello was graduated in 1932 from the medical school of Georgetown University in Washington, D. C. He interned at St. Elizabeth Hospital in Elizabeth and subsequently became affiliated with the staffs of both that institution and the Alexian Brothers Hospital. In a 5-year tour of duty in the Army during World War II, he rose from first lieutenant to major. In 1951 he was appointed to the Board of Education of his native city. Dr. Novello was active in industrial medicine, serving several large factories in Union County. He was also active in the Knights of Columbus and in Athletic and Boys' Club work.

DR. LOUIS S. PENTEL

Dr. Louis S. Pentel of West New York died on July 1. Born in New York City in 1896, Dr. Pentel had resided in New Jersey for almost fifty years. He was graduated in 1925 from the Baylor University, College of Medicine, and he opened his office for the practice of medicine in West New York in 1926. He was a physician for the West New York school system, and at one time was president of the North Hudson Physicians' Association. Dr. Pentel was a member of the Hudson County Medical Society.

During World War II, Dr. Pentel served in the Army and was active in American Legion affairs. He was a well known stamp collector, and at one time was president of the North Hudson Philatelic Society. Dr. Pentel was an attending physician at the North Hudson Hospital in Weehawken.

DR. ALEXANDER SOCHACKI

On July 26, Dr. Alexander Sochacki, a well-known South Jersey allergist, died at his office in Camden. Born in 1903, Dr. Sochacki was graduated from the medical school of the University of Pennsylvania in 1928. He came to New Jersey to intern at the Cooper Hospital in Camden and remained affiliated with that hospital for the rest of his life. He was active in the affairs of the Camden County Medical Society. Dr. Sochacki was a Fellow of the American College of Allergists.

DR. NATHAN SWERN

The medical director of the St. Francis Hospital in Trenton, Dr. Nathan Swern, died suddenly on July 27. Dr. Swern was born in Trenton in 1897 and was graduated in 1922 from the Jefferson Medical College. He returned to his native city to intern at St. Francis Hospital and to engage in private practice. Always interested in internal medicine, he became a diplomate in that specialty. At medical school he won his A.O.A. key. He was medical consultant at several hospitals, and was active in the work of the Mercer County Medical Society, and in the affairs of the Trenton Rotary Club.

DR. PAUL C. WIESENFELD

At the early age of 44, Dr. Paul Wiesenfe'd died suddenly of a heart attack on August 9. A diplomate in orthopedics, he was an orthopedic staff member or consultant at several hospitals in the Middlesex County area. Dr. Wiesenfeld was graduated in 1940 at the medical school of the Royal College of Edinburgh, Scotland. He interned at the Perth Amboy General Hospital and then took a surgical residency at St. Luke's Hospital in New York and at the Orange Orthopedic Hospital in New Jersey. He was a frequent contributor to this JOURNAL. Dr. Wiesenfeld belonged to the American Academy of Orthopedic Surgery and was a Fellow of the International College of Surgeons.

DR. EMANUEL YADKOWSKY

One of New Jersey's pioneer allergists, Dr. Emanuel Yadkowsky died on August 23 at the age of 78. Dr. Yadkowsky was graduated in 1903 from Bellevue and came to Newark the following year. He served the people of the Newark area for a half a century thereafter. Dr. Yadkowsky was the Beth Israel Hospital's first pathologist. He was one of the founding physicians there and one of the earliest doctors in New Jersey to develop a skill in microscopy. He limited his practice to internal medicine, and devoted special attention to allergy at a time when the specialty scarcely existed. He established his private office on High Street, Newark, near Kinney Street, at a time when that was one of North Jersey's choicest residential areas. And there he remained for more than 50 years refusing to follow the fashionable trend to suburbs or office buildings, but staying near his old patients and in the center of the area where, for the half century, he had been the neighborhood doctor.

New Army Medical Formulary

The Army Medical Service *Formulary*—the first publication of its kind in the history of military medicine—was released last month for world-wide distribution.

Compiled by Lt. Col. William L. Austin, Chief Pharmacy Consultant to the Surgeon General, the *Formulary* is a convenient reference source on the Army's current therapeutic inventory.

The *Formulary,* published as Technical Manual 8-245, is available on request through Adjutant General channels. It is now the basic source of reference for clear, concise, and definitive information concerning drugs available to military physicians.

The *Formulary* is divided into four parts. One contains general information on pharmacy management, prescription writing, and the Therapeutic Agents Board system. Part Two includes monographs on individual drugs, arranged according to therapeutic use or pharmacologic action. Part Three comprises standard stock formulas for preparations manufactured frequently in Army pharmacies.

The *Formulary* is a practical guide to the selection of the "drug of choice" for therapeutic practices for Army Medical personnel who are transferred from one medical treatment facility to another. The *Formulary's* pocket-size design in looseleaf form affords maximum flexibility, since revisions can be inserted easily and rapidly without arduous "posting."

Announcements • • •

Enlarged Seton Hall Graduate Program

Seton Hall College of Medicine and Dentistry announces a much enlarged graduate program for 1958-59. A total of 42 special courses are offered in 15 facilities throughout the state. Practically every specialty of medicine and surgery is represented and programs are available in nearly all large cities in northern New Jersey. For details write to Dr. Otto Brandman, Assistant Director of Medical Education, Seton Hall College, 31 Clinton St., Newark 2, N. J.

Research in Clinical Practice

During the fortnight beginning October 13, the New York Academy of Medicine will hold its Annual Graduate Week. This year's theme is "Research Contributions to Clinical Practice." The program includes daily panel sessions and evening lectures. For details write to Postgraduate Week, Academy of Medicine, 2 East 103 Street, New York 29, N. Y. There are no fees involved in participating in this colloquium.

Courses on Chest Disease

The American College of Chest Physicians announces a course in Chicago on "Cardiopulmonary Physiology" (October 13 to 17) and one in New York on "Recent Advances in Chest Diseases." The New York course is from November 10 to November 14. For details, write to American College of Chest Physicians at 112 East Chestnut Street, Chicago (11), Illinois.

Address of Virology Bureau

Please change your office records to show that the State Health Department's Bureau of Virology is now at the Madden Building, Donnelly Memorial Hospitals, Hamilton Avenue, Trenton. Telephone is JUniper 7-7045.

Medico-Legal Meeting

On Wednesday evening, October 15, there will be a discussion on the use of impartial medical panels in developing medical evidence at trials. This symposium is under the auspices of the Medico-Legal Society of New Jersey. The meeting is scheduled for the Robert Treat Hotel on Park Place, Newark, 8:30 p.m. All readers of this JOURNAL are invited to attend. Speakers at this symposium will include The Honorable Edward Gaulkin, Superior Court of New Jersey, Dr. Howard R. Craig, Director of the New York Academy of Medicine and Dr. Daniel Featherston, Chairman of the Judicial Council of The Medical Society of New Jersey.

Round-the-World Graduate Study Tour

The International College of Surgeons will hold an Around-the-World Graduate Clinic and Lecture Tour, beginning with departure from San Francisco on October 10. Return to New York will be on December 3. This carefully planned itinerary will afford an opportunity to attend specially arranged surgical clinics and demonstrations in the important cities of Hawaii, Japan, Hong Kong. the Philippines, Thailand, India, Egypt, Turkey, Greece, Italy and Spain.

Further information may be had from Dr. Arnold S. Jackson, 16 South Henry Street, Madison 3, Wisconsin.

Inhalation Therapy Course

A course to train inhalation therapists for hospital service will be offered at St. Elizabeth Hospital in Elizabeth, New Jersey, beginning on October 14. The course covers cardiopulmonary anatomy and physiology, technics of inhalation therapy, record keeping and administration. This is a 2-half-days-a-week course which runs for six months. For details write to School of Inhalation Therapy, St. Elizabeth Hospital, Elizabeth (2), New Jersey.

Industrial Health Conference

The Far Hills Inn at Somerville, N. J. has been selected as the site for the next meeting of the New Jersey Industrial Health Conference. This is scheduled for October 18 and the opening paper at 10:00 a.m. concerns "The Disturbed Adolescent, our Future Employee." Other papers are scheduled, as well as exhibits. For further information write to Dr. Robert E. Eckhardt, P. O. Box 45, Linden, N. J.

Gastro-Enterologic Convention

October 20 to 22 are the dates, the Jung Hotel in New Orleans is the place for the next convention of the American College of Gastro-enterology. Included in the program are panel discussions on steroids, carcinoma and functional gastro-intestinal disorders. On October 23, Dr. I. Snapper and Dr. Owen Wangensteen will start a 3-day graduate course in gastro-enterology. For more details, write to American College of Gastro-enterology at 33 West 60 Street, New York 23, New York.

Diabetes Symposium

Wednesday, October 29, is the date of the sixth annual symposium on diabetes mellitus, to be held at the Martland Medical Center, 116 Fairmount Ave., Newark, N. J. Developed by the New Jersey Diabetes Association in cooperation with the New Jersey State Department of Health, the symposium covers all aspects of diabetes practice and starts at 9:00 a.m. Exhibits, lectures, demonstrations, and conferences are scheduled. For details write to Dr. Otto C. Brandman, 558 Prospect St., Maplewood, N. J.

Hypnosis Workshop

Physicians and dentists interested in hypnosis are invited to a workshop at the Hotel Morrison in Chicago, October 27, 28 and 29 this year. For more details, write to Dr. William S. Kroger, 750 North Michigan Avenue, Chicago 11, Illinois.

Cancer of the Lower Bowel

On October 20 and 21 in New York City, the American Cancer Society is scheduling a symposium on carcinoma of the lower bowel. The first session 9 a.m. Monday, October 20, is devoted to the pathogenesis of such cancer. The 2 p.m. session on Monday will discuss diagnosis. Problems of management will be taken up at the two sessions on October 21. For details, write to Director of Professional Education, American Cancer Society, 521 West 57 Street, New York (19), N. Y.

Meeting of Medical Assistants

On October 31, in Chicago, will begin the 3-day sessions of the American Association of Medical Assistants. Included will be papers or presentations on ethics, record-keeping, office machinery, telephone technics, handling emergencies, medico-legal problems, personal grooming, public relations, x-ray methods, and aseptic technics. For more details, write to Mrs. Mabel Dove at 1100 Church St., Lynchburg, Virginia.

Proctologists Meet on Shipboard

The New Jersey Proctologic Society, together with societies of adjacent states, will meet on board the *Ocean Monarch* from Friday, November 14 to Saturday, November 22. This vessel is going from New York to Nassau with a stopover at Bermuda. During the shipboard meeting all practical phases of proctology will be covered. For further details write to Dr. N. L. Freund, 163 Ocean Ave., Brooklyn 25, N. Y.

International College of Surgeons

Physicians who would like to spend part of the winter in Miami Beach may do so with a clear conscience by attending the regional meeting of the International College of Surgeons, to be held in Miami Beach January 4 to 7, 1959. For details write to Dr. H. O. Hallstrand, 7210 Red Road, South Miami, Fa.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Healthful School Living. Chicago 1958. American Medical Association and National Education Association. Pp. 323. ($5)

The AMA and the National Education Association appointed a joint committee to study school health problems. This is their report. It covers such items as sewerage disposal, heating, school luncheons, fire control, ventilation, sanitation, accident prevention, and general school housekeeping. The text is a mixture of practical little pointers (the height of toilet bowls above the floor in elementary schools, for example) and obvious generalities (the teacher should be enthusiastic, cheerful, friendly, objective, healthy and fair). Material on lighting, heating and housekeeping is highly practical. The index is unusually full. The book includes a do-it-yourself appraisal schedule with which any school physician can work to spot defects in health programming. This is a useful manual for any school physician, or indeed, for any parent whose child attends a public school.

VICTOR HUBERMAN, M.D.

New and Nonofficial Drugs, 1958. By the Council on Drugs of the American Medical Association. Philadelphia, Lippincott, 1958. Pp. 631. ($3.35)

As regular and welcome as spring comes the annual edition of *New and Nonofficial Drugs* (formerly *New and Nonofficial Remedies*) prepared by the American Medical Association. This volume includes preparations commonly available in the United States that have not previously been included and are not found in the *Pharmacopeia*. Drugs are grouped by clinical function and both the generic and trade names are given. Bound into the volume is a description of official and regulatory agencies, a conversion table, a summary of the work of the Council on Drugs, and a listing of monographs added and deleted since the 1957 edition.

HENRY A. DAVIDSON, M.D.

Preventive Medicine for the Doctor in his Community. By Hugh Rodman Leavell, M.D. and E. Gurney Clark, M.D. Ed. 2, Mc-Graw-Hill Book Co., Inc., Blakiston Division, New York, 1958. Pp. 689. ($10.00)

This book, a second edition of the authors' *Textbook of Preventive Medicine* published five years ago, presents an approach to health promotion and disease promotion. Twenty-one authorities discuss various aspects of preventive medicine pertaining to individual and community health in this expanded volume. Brought up to date and rearranged according to suggestions from reviewers and teachers of preventive medicine, it includes a new chapter on the natural history and prevention of oral disease. A chapter on multiple screening examinations from the previous edition has been combined with one on long term illness. The concluding section concerns public health—preventive medicine as organized community action.

The present volume is directed primarily at developing a point of view—a modern basis for the science of disease prevention. Designed for student and practitioner alike, it emphasizes prevention and early detection of deviations from health. Prompt diagnosis and development of host resistance are the specific goals sought by the application of the epidemiologic method for solving problems in individuals and groups. Preventive factors are reviewed in allergy, maternal and child health, medical genetics and numerous related subjects. Selected references at the end of each of the 21 chapters and an index complete this worthwhile volume.

FRED B. ROGERS, M.D.

The Therapeutic Uses of Adhesive Tape. Pp. 130 Published 1958 by Johnson and Johnson, New Brunswick, N. J. Gratis to physicians.

Handsomely illustrated, this slim, hard-bound manual shows how to use adhesive tape for strains, sprains, fractures, dislocations and wounds. There is a chapter on the use of tape to prevent athletic injury and another on the application of adhesive dressings in industrial injuries. As might be expected, the book plugs J & J products by trade-name. However, this does not detract from the authenticity and usefulness of 100 illustrations.

ULYSSES M. FRANK, M.D.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI September, 1958 No. 9

Clinical Experience with 682 Cases of Asian Influenza

Lawrence S. Greene, Lieutenant, MC, USNR, Thomas E. Hair, Jr., Lieutenant, MC, USNR, United States Armed Forces Medical Journal, March, 1958.

● A study of 682 cases of Asian influenza provides convincing evidence that influenza may be recognized easily and accurately by clinical means.

Influenza has affected mankind with varying intensity for many years, but only since the epidemic of 1933, when type A influenza virus was isolated, has this disease yielded to accurate laboratory as well as clinical diagnosis. In April 1957 influenza once again began one of its characteristic peregrinations, spreading rapidly from Asia to Europe and the United States, and eventually involving most of the world. The causative virus of this "Asian influenza" was identified as A/Japan/305/57.

The clinical material herein presented concerns 682 cases of Asian influenza seen during October and November 1957 in an epidemic characterized by sudden, dramatic onset in a select population of previously active, healthy, military personnel.

Symptoms. The distribution of symptoms encountered in the 651 uncomplicated cases of influenza appear to be non-specific, but distinct individual characteristics of the following six symptoms were easily discernible and contributed greatly to the facility with which the clinical diagnosis could be made:

Headache, characteristically dull, severe, and unremitting, located frontally or retro-orbitally, and often associated with marked somnolence, was a repeated complaint.

Fatigue, overpowering in nature, completely incapacitating healthy young men.

Cough, typically dry, irritating, and non productive was characteristic.

Chills, more correctly frank rigors, was a dependable, readily recognized symptom.

Ocular pain, aggravated by any and all motion of the eyes, was an unmistakable finding.

Myalgia, referred to the low back area, was an often-repeated complaint.

In contrast, other common symptoms such as soreness of the throat, chest pain, anorexia, nausea, and vomiting were notably insignificant.

Physical Examination. The findings on physical examination of the chest, including inspection, palpation, percussion, and auscultation, were strikingly negative. Very rarely were minor scattered rhonchi, occasional wheezes, and less frequent discrete rales heard. Plethoric facies associated with elevated temperatures were found uniformly. Pharyngeal infection, nonspecific in type, and associated with discrete, mobile, slightly tender cervical lymph nodes, was common.

Laboratory Studies. Laboratory findings were non-specific and of little diagnostic value. Because of the involvement of many of our laboratory personnel, bacteriologic studies were of necessity minimal. Hematologic observations revealed normal hemoglobin. The white blood cell count generally was found to be between 5,000 and 9,000 per cu. mm. with little in the differential count that varied from normal. A relative lymphocytosis was observed frequently. Urinary abnormalities were infrequent and cleared spontaneously. Rotengenograms of the chest were taken on all patients. In uncomplicated cases of influenza the chest films were uniformly normal.

Shortly after the onset of the epidemic, blood specimens were drawn from 16 patients, in order to determine the nature of the afflicting virus. Subsequently, only one patient from each 100 was studied serologically. A four-fold or greater increase in antibody titer in the convalescent specimen as compared to the acute stage specimen

was considered positive evidence of infection. The results of these studies indicated that the offending agent was the Asian influenza virus, A/Japan/305/57.

Effect of Vaccination. Vaccination of local military personnel was begun as soon as the polyvalent vaccine with Asian strain included became available for wide-scale use in the area. Personnel were immunized on one occasion by intradermal injection of 0.1 ml. in each arm. Of the 682 patients with influenza in this series, 376 (55 per cent) had not been immunized, 201 (30 per cent) had been immunized one week before they became ill, and 105 (15 per cent) had been immunized two weeks prior to the onset of illness. There was no discernible difference in clinical picture, complications, or course of the disease between the immunized and nonimmunized groups.

Temperature Curve. Among the uncomplicated cases 91 per cent had a temperature curve characterized by a progressive downward trend, reaching normal levels in 48 to 72 hours without salicylate therapy. In 9 per cent of the cases, there was a persistent febrile response which reached normal only after five to seven days of hospitalization.

Nature and Frequency of Complications. As is well recognized, the principal dangers in an influenza epidemic lie in the complicating illnesses. The most important clinical aid in detecting a developing complication was the characteristic temperature response if continuous salicylate therapy was not employed. Every one of the 31 patients in our series who developed a complicating illness failed to become afebrile in 72 hours. Their temperature curves became normal only after six to seven days.

Although this type of response was exactly like that found in 9 per cent of the uncomplicated cases in this series, it provides an urgent clinical warning to the practicing physician. When such a febrile response is encountered, careful re-evaluation of the case with appropriate diagnostic procedures, including the necessary radiologic technics, is in order, to rule out the presence of a complicating infection.

Therapy and Length of Hospitalization. The principal treatment of uncomplicated cases in this series was bed rest, supported by fluids, administered by mouth in large quantities. Simple expectorants were used, and where indicated, mild analgesics and nasal decongestants were used. With this simple but effective regimen, the average hospital stay was six days. Hospitalization was necessary only as an epidemiologic control measure.

We used only symptomatic therapy in all cases of this series, with the exception of appropriate chemotherapy when a distinct complication attributed to secondary infection occurred.

This clinical study provided convincing evidence that complications arising from influenza are easily and accurately recognized by clinical means. Provided sustained antipyretic therapy in the form of salicylates is not employed, a characteristic febrile response provides a reliable clue to the presence of a complication. When such a febrile reaction is observed, the physician must carefully reappraise the situation and search for the locus of a secondary infection. Once discovered, the complication can be effectively treated. Inexpensive, readily-available medications are adequate for successful therapy of influenza.

SUMMARY. A clinical study was made of 682 cases of influenza seen in a sudden epidemic in a military population and serologically confirmed as caused by the Asian influenza virus. It was found that the disease presented a distinct symptom complex which made possible accurate diagnosis on a clinical basis. Physical and laboratory findings tended to be insignificant in uncomplicated cases. In 91 per cent, the temperature decreased steadily to reach normal in 40 to 72 hours, but in 9 per cent it fluctuated between 101° and 102° F for several days. Immunization either one or two weeks prior to onset of illness had no discernible effect on the clinical picture or course of the disease.

Symptomatic treatment without use of antibiotics resulted in rapid recovery with no fatalities. Complications in 4.6 per cent of the cases were successfully treated with antimicrobial agents. Provided sustained salicylate therapy is not used, every case in which a complicating bacterial illness occurred was heralded by a characteristic elevated temperature for more than 72 hours providing a clear warning that search for such a possible complication should be undertaken.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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JDR:ep

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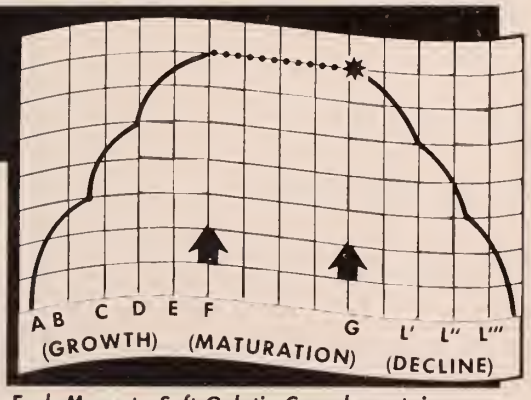
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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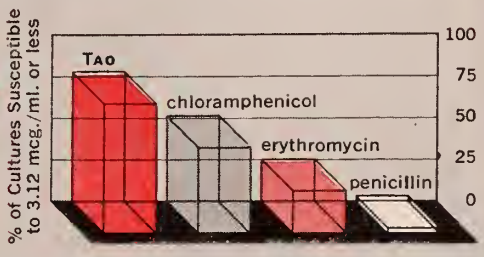
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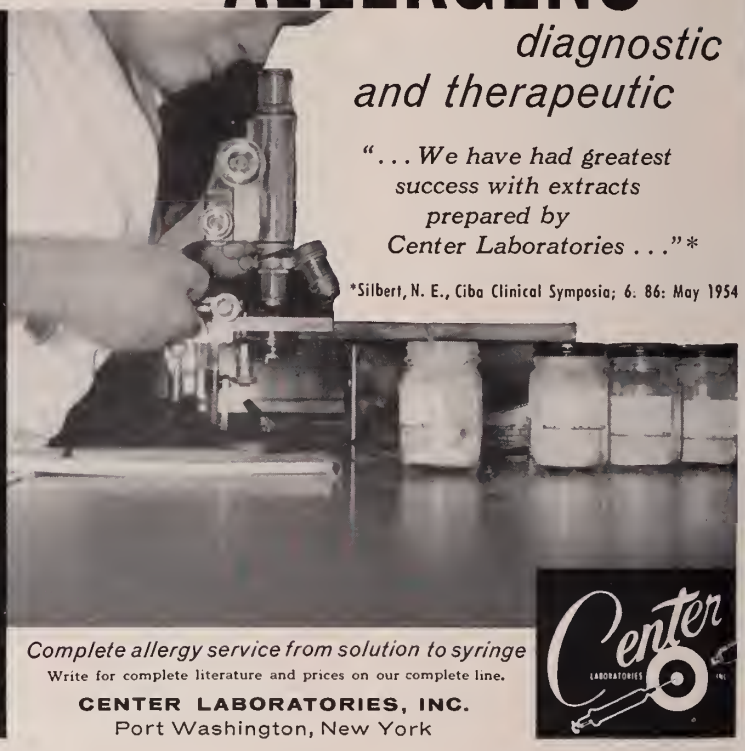
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References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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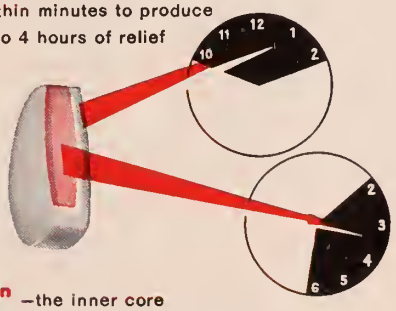
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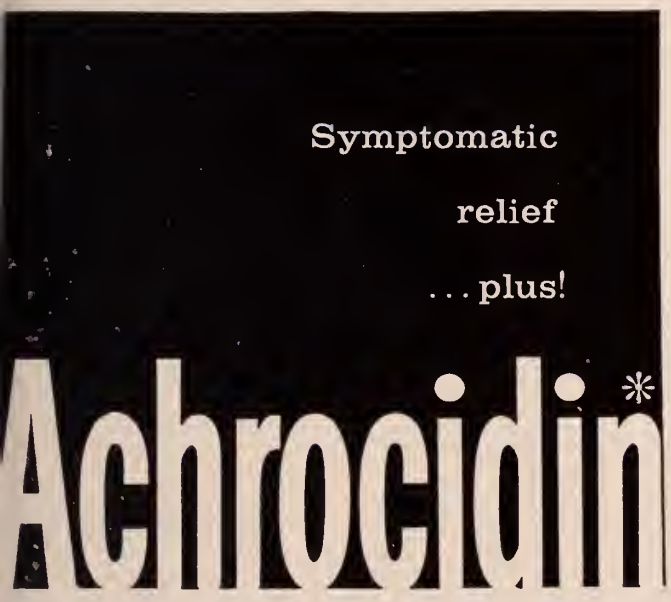
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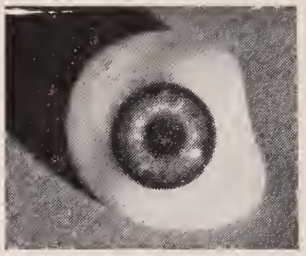
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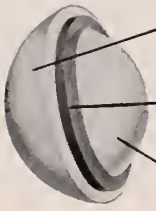
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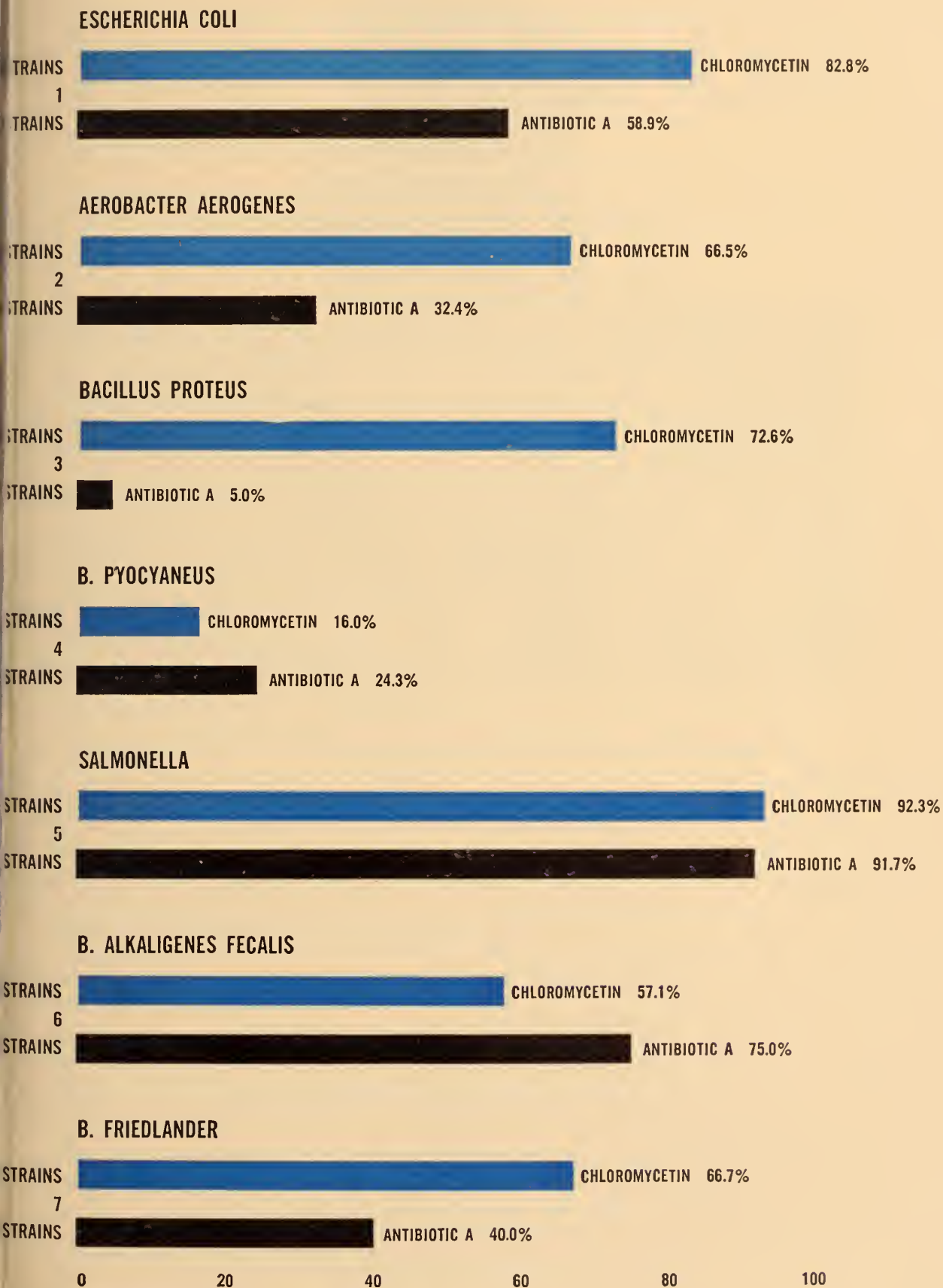
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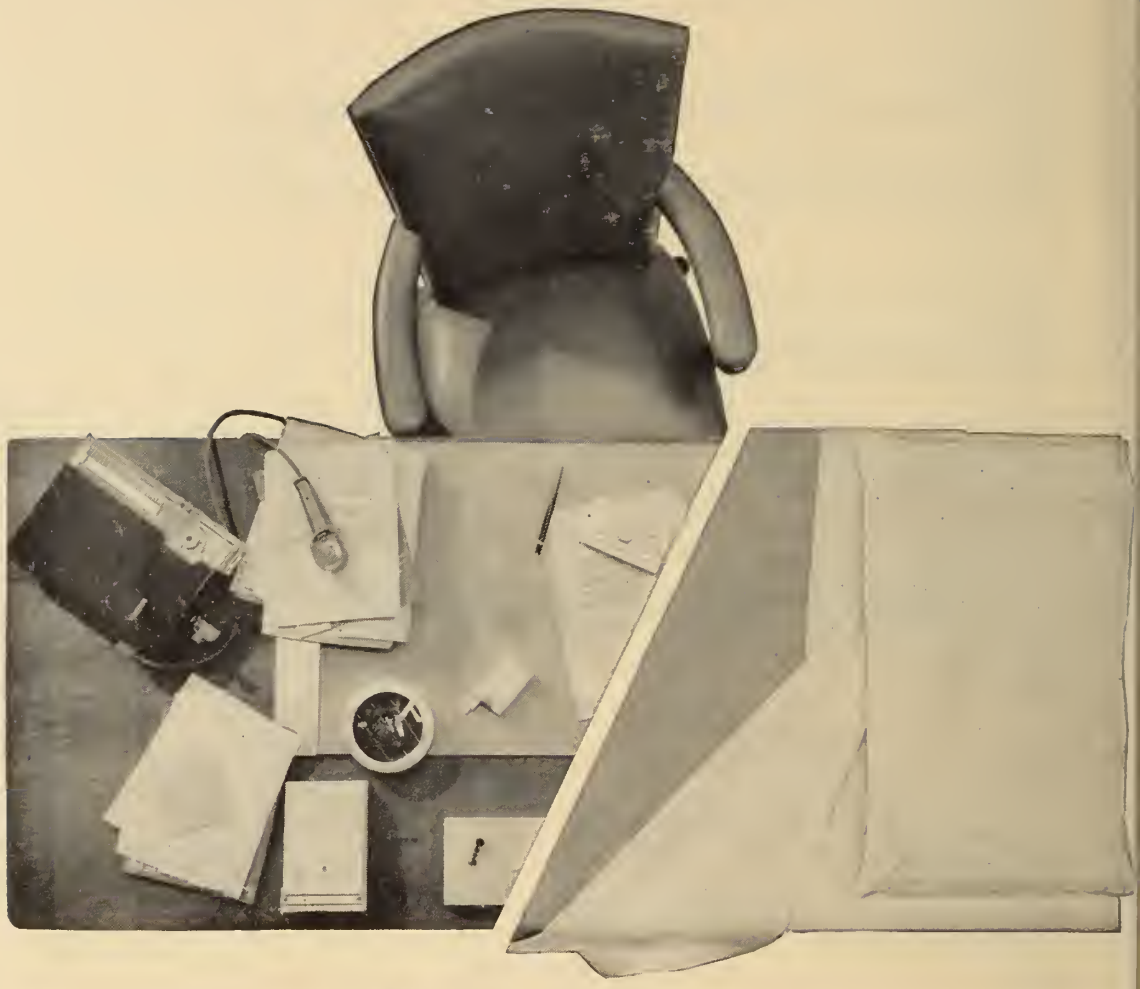
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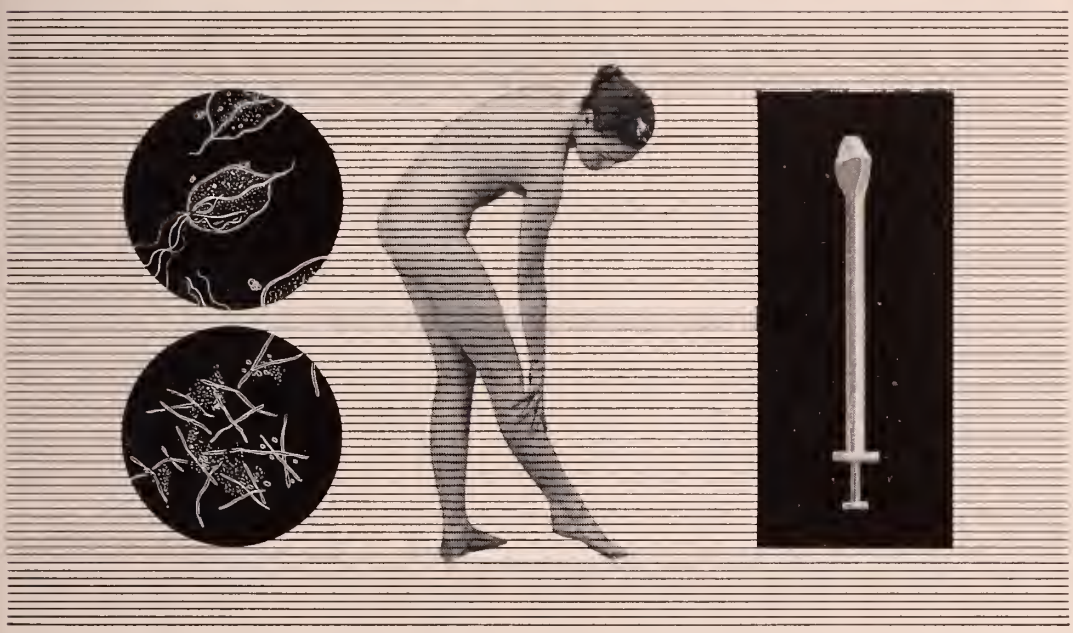
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FOR FLAGELLATE AND FUNGAL VAGINITIS



Floraquin®

Destroys Common Vaginal Pathogens; Rebuilds Normal Bacterial Barrier

Whenever a woman complains of vaginal discharge with pruritus, a trichomonal infection[1] must be suspected. Moniliasis, the second most frequent cause[2] of leukorrhea, often occurs[3] in conjunction with diabetes mellitus, pregnancy and estrogen or broad spectrum antibiotic therapy. Commonly used douches wash away normal acid secretions and protective Döderlein bacilli, thus tending to aggravate the problem.

Floraquin, containing Diodoquin® (diiodohydroxyquin, U.S.P.), eliminates infection and provides boric acid and sugar to restore the acidic pH which favors replacement of pathogens by normal Döderlein bacilli. The danger of recurrence is thus minimized.

Pitt reports[2] consistently good results after daily vaginal insufflation of Floraquin powder for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles.

Intravaginal Applicator for Improved Treatment of Vaginitis—

This smooth, unbreakable, plastic plunger device is designed for simplified insertion of Floraquin tablets by the patient; it places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. A Floraquin applicator is supplied with each box of 50 tablets.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

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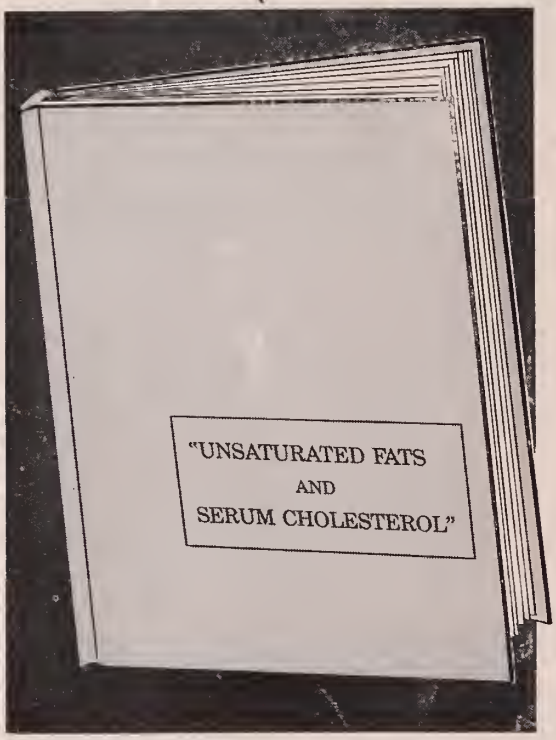
1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157*:126 (Jan. 8) 1955.
2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25*:182 (Feb.) 1956.
3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51*:1494 (June 15) 1956.

SEARLE

NEW BOOK . . . just off the press . . . send now for your FREE copy

"Unsaturated Fats and Serum Cholesterol"

A review of the latest concepts and results of current research



This new book contains the most up-to-date bibliography of current research on: 1. The origin and behavior of cholesterol in the human body; 2. The effect of different dietary fats on serum cholesterol levels; 3. The nature of the active components in vegetable oils; and 4. Suggestions for practical diets.

Now ready for distribution to Physicians by the makers of MAZOLA Corn Oil, this book supplements the 1957 monograph, "Vegetable Oils in Nutrition" and provides a broader coverage of this important subject.

As a regular part of daily meals

MAZOLA® CORN OIL

can be used for control of Serum Cholesterol levels

MAZOLA CORN OIL . . . the only leading oil made from golden corn, is rich in the important unsaturated fatty acids—When an adequate amount of Mazola is part of the daily meals, elevated serum cholesterol levels tend to be lowered . . . normal levels tend to stay level . . .

MAZOLA CORN OIL is a natural food, *and* cholesterol free, can easily be included as part of the every day meals . . . simply and without seriously disturbing the patient's usual eating habits . . . in salads, baking and other cooking processes.

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Please send me a free copy of your latest reference book, "Unsaturated Fats and Serum Cholesterol."

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Technical Pamphlet, "Facts about MAZOLA Corn Oil," also available. Provides technical information on chemical and physical properties. Check here if you wish a copy of this pamphlet... ☐

CORN PRODUCTS REFINING COMPANY





Each **TABLESPOONFUL** *of* **MAZOLA**

Provides approximately

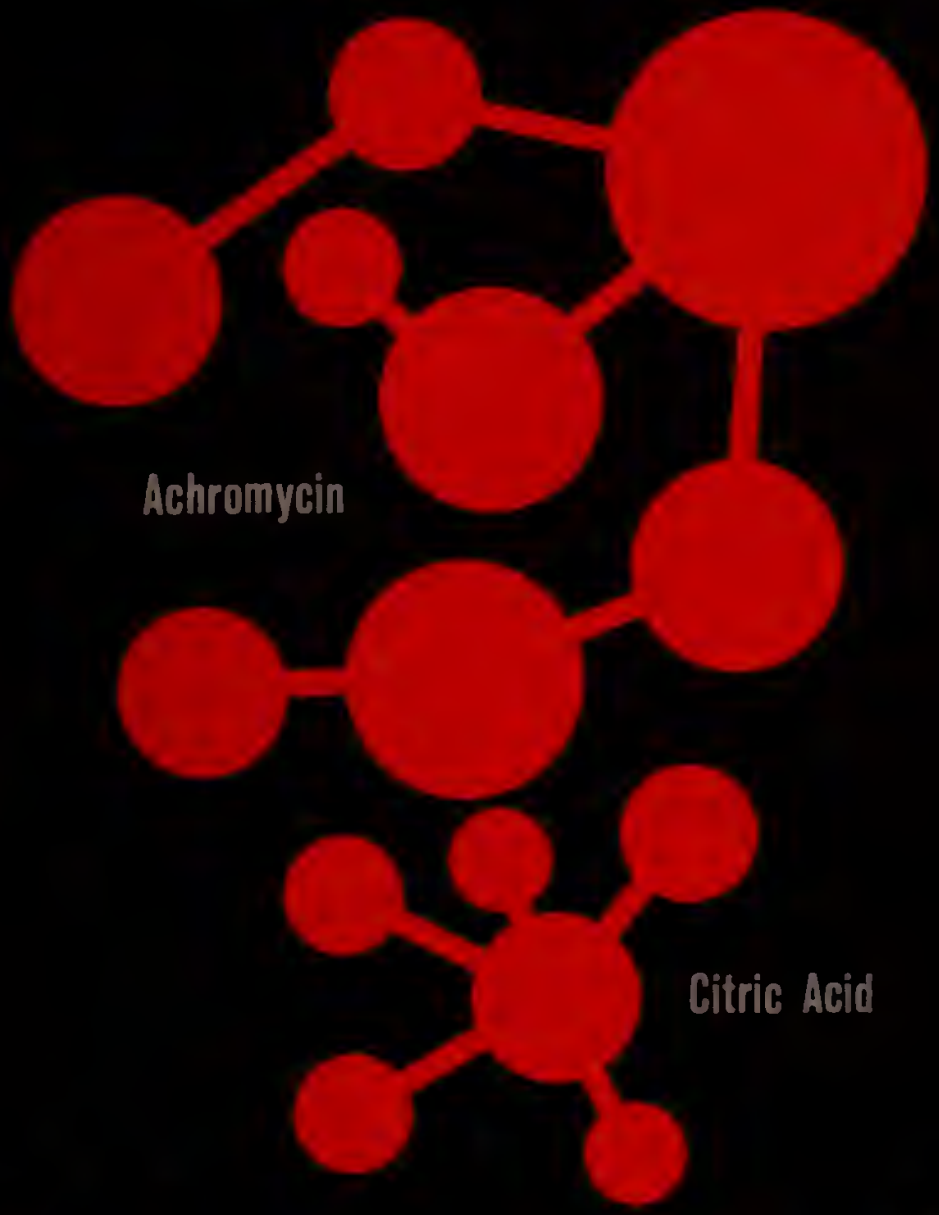
LINOLEIC ACID	**7.4 Gm.**
Sitosterols	130.0 mg.
Natural tocopherols	15.0 mg.
Cholesterol	0
Weight 14 Gm.	Calories 126

Total unsaturated Fatty Acids—85%

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 Tbsp.
For a 3000 calorie diet	2.5 Tbsp.
For a 2000 calorie diet	1.5 Tbsp.

for unsurpassed performance at the clinical level . . .



Achromycin*V

What these 3 ions mean to your patients

CITRIC ACID

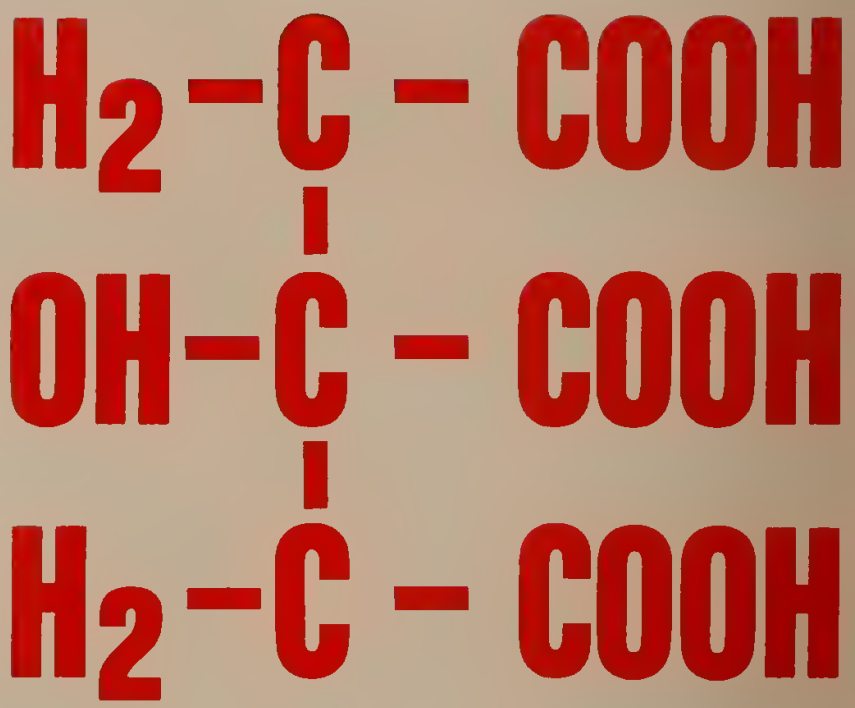
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additive

choice

of

Lederle Research



triple assurance of maximum antibiotic potency

In developing ACHROMYCIN V, Lederle research scientists aimed for patient response rather than laboratory results, and chose citric acid for its outstanding value under clinical conditions. Citric acid is unique in that it contains THREE free carboxyl groups in every molecule to combine with the metallic ions which interfere with gastrointestinal absorption. This activity thus leaves the pure active tetracycline molecule available for full absorption and rapid action at the site of infection.

Achromycin*V

TETRACYCLINE WITH CITRIC ACID LEDERLE

ASSURES EVERY PATIENT PRECISE ANTIBIOTIC ACTION UNDER THE VARIED CONDITIONS OF REALISTIC CLINICAL PRACTICE

produces optimal gastric conditions

Ideally, most antibiotics are given on an empty stomach Since citric acid helps control unfavorable variances in gastric content,conditions in the stomach are optimal with ACHROMYCIN V tetracycline with citric acid.

prevents interference with absorption

Sequestering of antibiotic molecules by free metallic ions, always present in the intestinal tract, can deprive patients of a full therapeutic dose. The three active carboxyl radicals which protect the action of ACHROMYCIN V trap these free cations and allow uninhibited antibiotic absorption.

provides for peak antibiotic action

At the site of infection where, in essence, all antibiotics are proved, ACHROMYCIN V combats a wide range of pathogens under optimal tissue conditions. Citric acid, a factor of medically established value in the natural acid-base regulating mechanism of the G.I. tract, facilitates a more complete, and rapid antibiotic action.

MORE DOCTORS PRESCRIBE ACHROMYCIN V THAN ANY OTHER BROAD-SPECTRUM ANTIBIOTIC

Lederle **LEDERLE LABORATORIES,** a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

*REG. U.S. PAT. OFF.

†Trademark *Patent #2,841,971



Supp-hose†*

FOR LEG FATIGUE AND MILD VARICOSITIES

Recent clinical research demonstrated the excellent value of Supp-hose for leg fatigue, and mild disorders where heavy surgical stockings are not prescribed. The advantage of Supp-hose is that it looks just like any sheer nylon stocking, thus it overcomes one of the main objections of the patient concerned about her appearance.

SO MANY WOMEN COMPLAIN ABOUT LEG FATIGUE!

As you know, expectant mothers, housewives, working women, and women with mild varicosities all complain about discomfort of the extremities. Supp-hose eases this leg fatigue and gives gentle support all day long. Yet Supp-hose contains no rubber! Every stitch is fine nylon with a special twist that provides an elastic quality.

A VERY ECONOMICAL STOCKING!

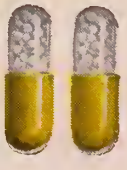
Patented Supp-hose costs a woman just one-third what she usually pays for heavier surgical stockings. And wear tests indicate Supp-hose should give five times the wear of ordinary nylons. Supp-hose is available in proportioned sizes in beige, natural and white. At drug and department stores.

KAYSER-ROTH HOSIERY COMPANY, Inc., 200 Madison Avenue, N. Y. 16, N. Y. Sold in Canada.

Now—the most widely prescribed tranquilizer[1] in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules



q. 12 h.

Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained* basis, without between-dose interrupti

"*The administration of meprobamate in sustained action form [Meprospan] produ a more uniform and sustained action . . . these capsules offer effectiveness at reduced dosage.*"[2]

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

WALLACE LABORATORIES, *New Brunswick, N. J.*

ARTHRITIS... OR GOUT?



GOUT—THE DIAGNOSTIC PROBLEM

Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

BENEMID®—AN EFFECTIVE URICOSURIC AGENT

'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

MSD MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

BENEMID is a trade-mark of Merck & Co., Inc.

NOW

efficient, reliable

Allergy testing and treatment

in **YOUR OWN OFFICE**



Yes, specific desensitation can be quickly, easily and accurately accomplished by every physician with a PUREX scratch or intradermal test kit. Rapid diagnosis is assured with guaranteed active PUREX allergenic extracts.

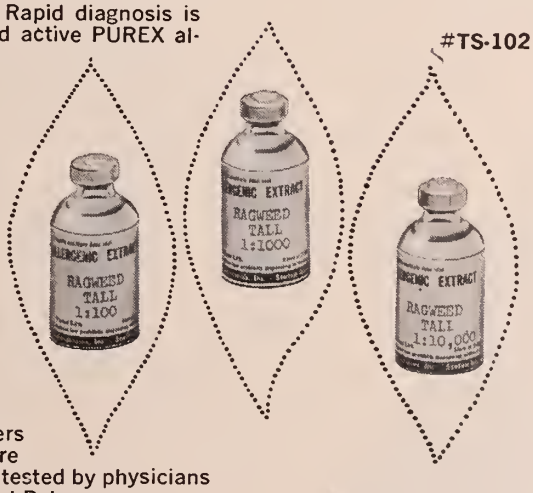
DIAGNOSTIC ALLERGENS TEST SETS in 5 cc vials

(available in scratch or intradermal kits)

#TS-101 90 unit Inhalant, Contactant & Ingestant set . . $120.

#TS-102 40 unit Pollen set . . . . . $ 50.

(Includes test sheets, scarifier, attractive office tray and complete instructions)



Specific desensitations by PUREX, for all irritants including food, dust, pollens and epidermals, promote active immunity of greater length than any other known medication. Inexpensive too! Available in 5 cc, 10 cc, 25 cc, 50 cc, and 125 cc sizes.

PUREX, the quality controlled ethical line of scratch, intradermal and prescription items; delivers biological extracts that are chemically and clinically tested by physicians for Activity and Consistent Potency. Thus assuring physicians that all extracts are manufactured under and meet the rigid specifications of the National Institutes of Health for PURITY, POTENCY and SAFETY!

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☐ Please send me complete information and price lists for your allergenic extracts.

Please ship the following:—

☐ 90 unit Inhalant, contactant & ingestant set $120.
☐ scratch ☐ intradermal

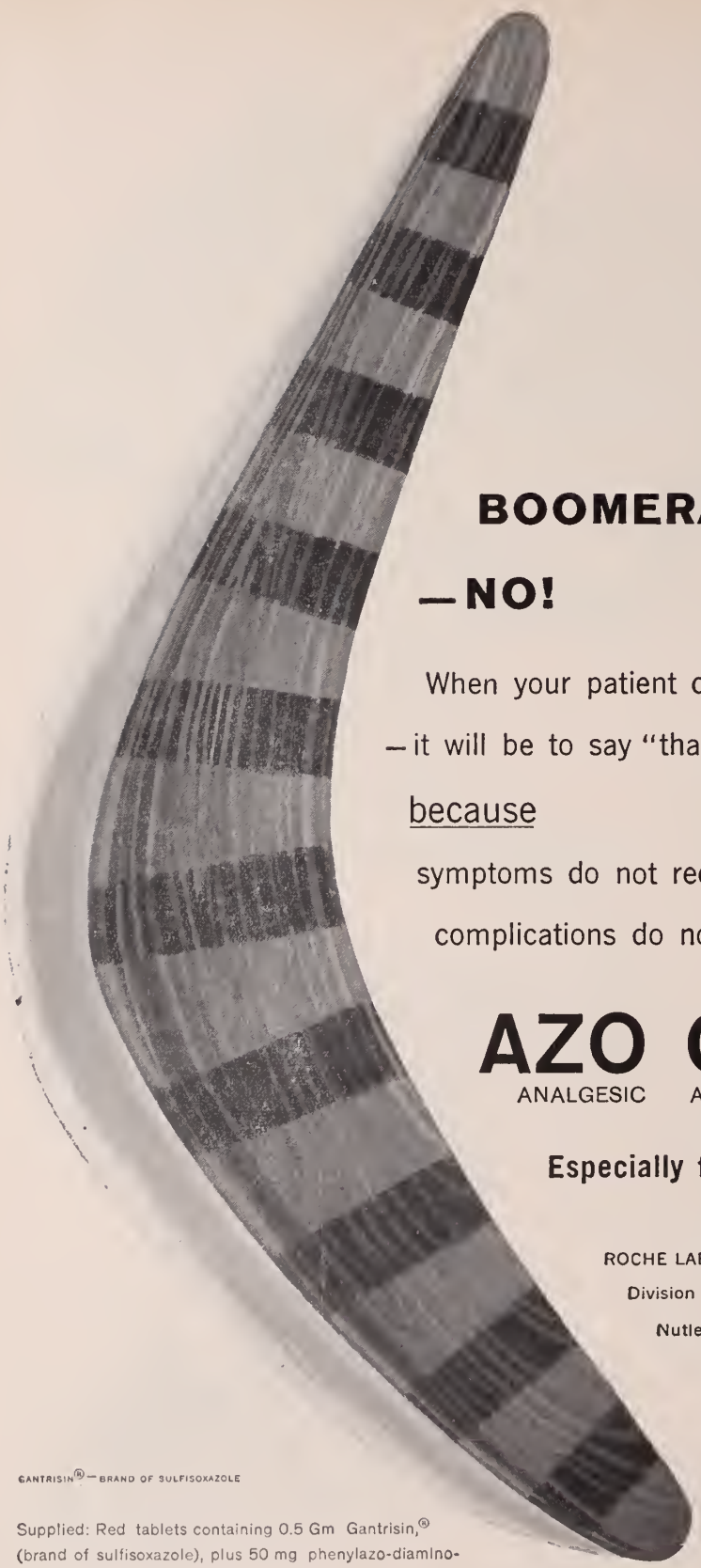
☐ 40 unit Pollen set . . . . . $ 50.
☐ scratch ☐ intradermal

Dr._____

Address_____

City_____ Zone____ State_____

☐ Check enclosed ☐ C.O.D. ☐ Bill me



BOOMERANG?

—NO!

When your patient calls again

—it will be to say "thanks"

because

symptoms do not recur—

complications do not supervene

AZO GANTRISIN

ANALGESIC ANTIBACTERIAL

Especially for urinary tract infections

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley 10, N.J.

ROCHE

GANTRISIN® — BRAND OF SULFISOXAZOLE

Supplied: Red tablets containing 0.5 Gm Gantrisin,® (brand of sulfisoxazole), plus 50 mg phenylazo-diamino-pyridine HCl, in bottles of 100 and 500.

New Milprem®-200

a new potency for greater dosage flexibility in treating the **menopause**



new
Milprem-200
200 mg. MILTOWN®
+
0.4 mg. CONJUGATED
ESTROGENS (EQUINE)

for prompt relief from emotional and somatic disturbances of ovarian decline

SUPPLIED: Bottles of 60 tablets.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods.
Should be adjusted to individual requirements.

ALSO AVAILABLE: Milprem-400 (400 mg. Miltown + 0.4 mg. Conjugated Estrogens, equine) in bottles of 60 tablets.

Literature and samples on request

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NEW styling
for known standard

To diabetics and their physicians, CLINITEST means rapid *and* reliable urine-sugar testing—standardized for accurate results every time. And now, the new streamlined model (No. 2105) gives your diabetics this standard test in the best looking, most efficient form.

CLINITEST®
BRAND

urine-sugar analysis set

- **functional:** full-view test tube always in place
- **refillable:** takes either bottle of 36 or sealed-in-foil CLINITEST reagent tablets
- **attractive:** two-tone, neutral gray plastic case

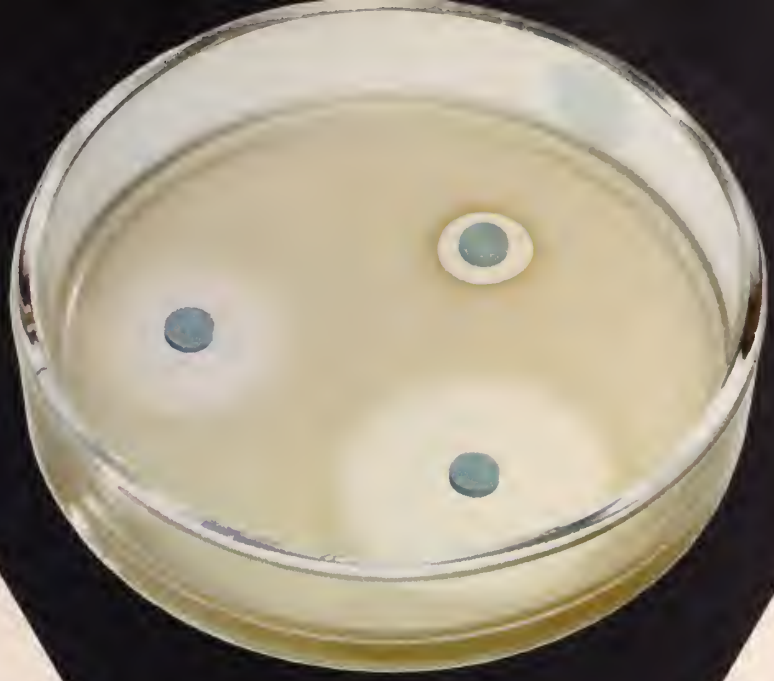
Model No. 2105 CLINITEST Urine-Sugar Analysis Set contains everything needed for accurate standardized testing: bottle of 36 CLINITEST Reagent Tablets, test tube, unbreakable dropper. color scale—instruction sheet, analysis record, diabetic's identification card



MODEL NO. 2105

AMES COMPANY, INC · ELKHART, INDIANA
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56758



for
the control
of all
coccal
infections

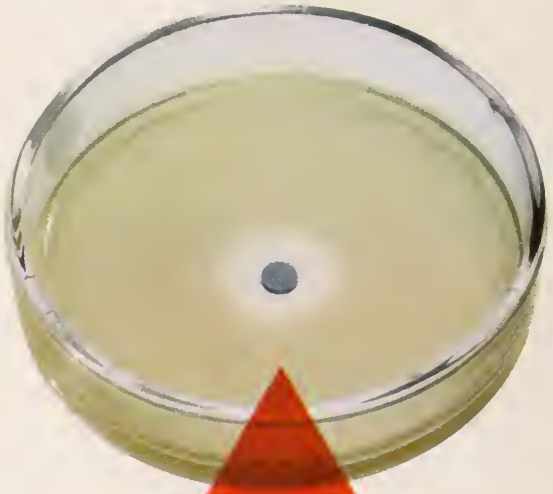
abbott's antibiotic triad



Erythrocin®

stearate

(Erythromycin Stearate, Abbott)



against staph-, strep- and pneumococci

indications:

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

dosage:

Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

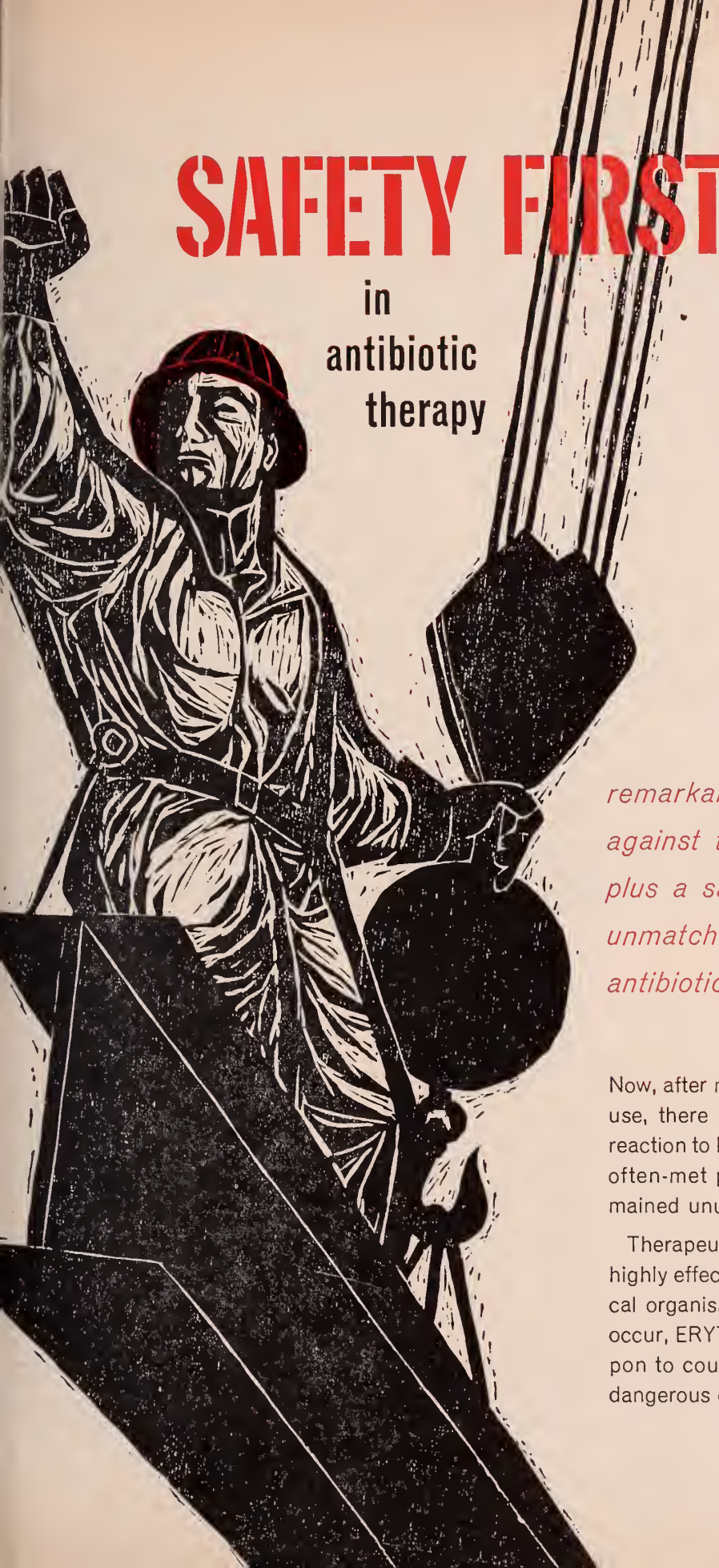
supplied:

In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab — Film-sealed tablets, Abbott; pat. applied for.

958, ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS

809027



SAFETY FIRST

in antibiotic therapy

remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

Abbott

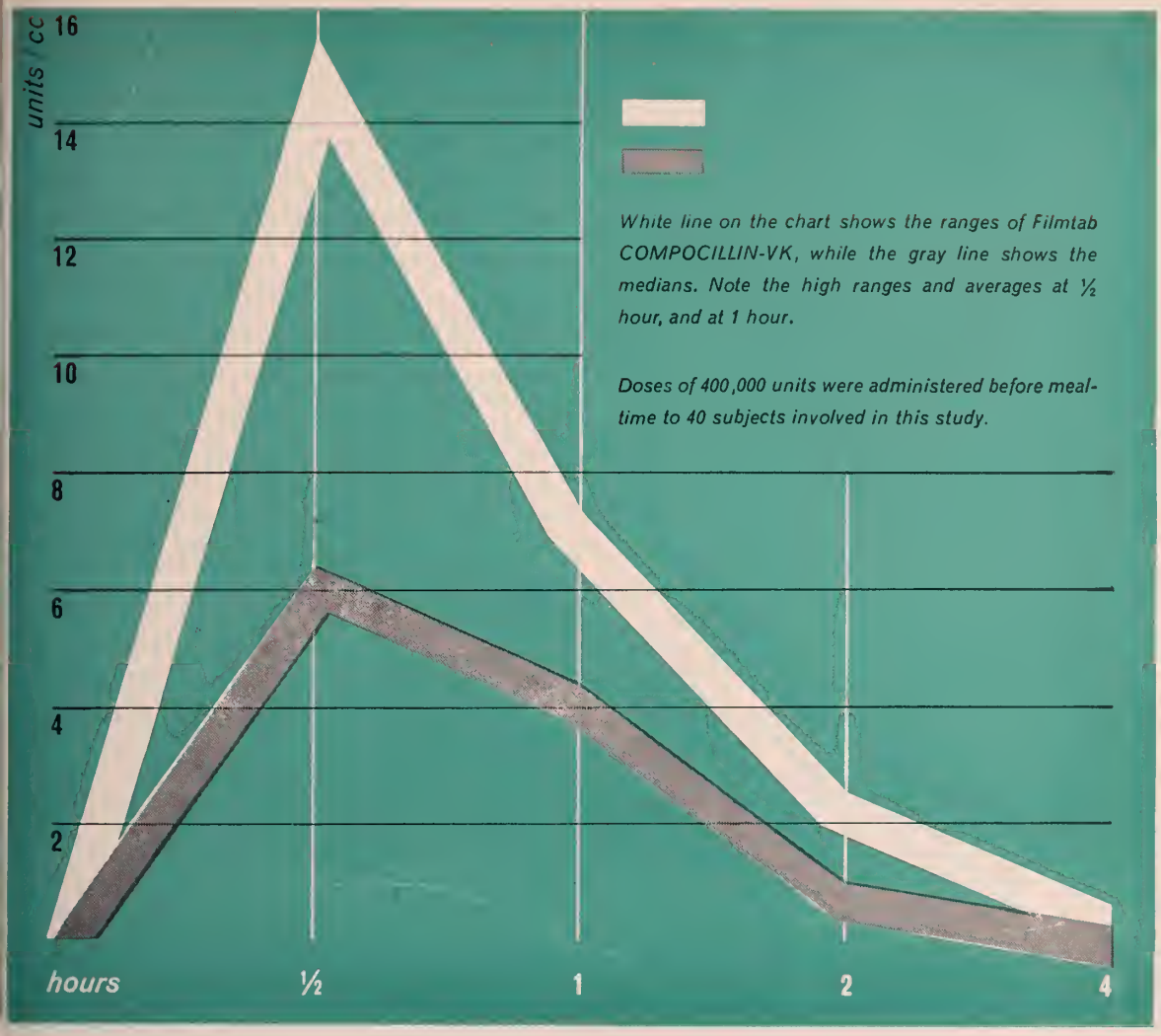


COMPOCILLIN®-VK

the higher blood levels of

Potassium
Penicillin V

809136



Now, in both Filmtab and Oral Solution, patients get high penicillin V blood levels with Compocillin-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

Compocillin-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

Compocillin-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott



indications:

Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections caused by organisms that resist all other antibiotics.

dosage:

Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight-or 12-hour intervals.

supplied:

In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.

SPONTIN®

(RISTOCETIN, ABBOTT)

609137

provides bactericidal action
against coccal infections

provides successful short-term therapy
against endocarditis[1]

provides clinical effectiveness against
resistant staphylococci and enterococci[2]

Now, after almost a year, SPONTIN has proved to be an exceptionally valuable agent for treating serious coccal infections.

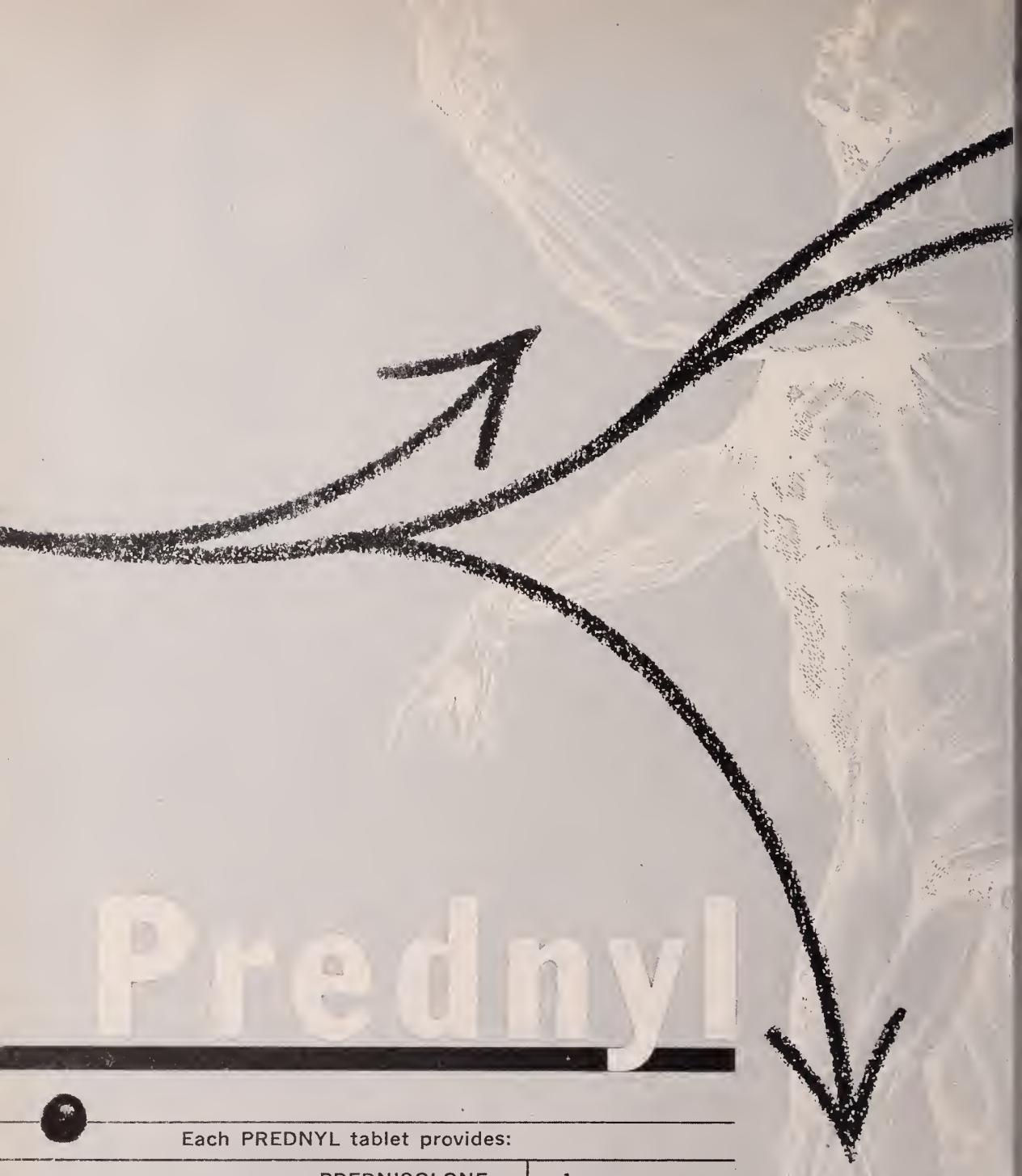
Some of the outstanding clinical responses to SPONTIN therapy involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. These were patients who were going downhill steadily—in spite of treatment by other antibiotics.

Results, of course, were not always good. Sometimes, the patient was treated with SPONTIN too late. Occasionally, there were side effects and SPONTIN had to be withdrawn. But generally, SPONTIN proved extremely useful and many times—lifesaving. Be sure your hospital has it stocked. Abbott

1. Antibiotics Annual, 1956-'57, p. 706.
2. Antibiotics Annual, 1957-'58, p. 180-7.

an important lifesaving antibiotic





Prednyl

Each PREDNYL tablet provides:

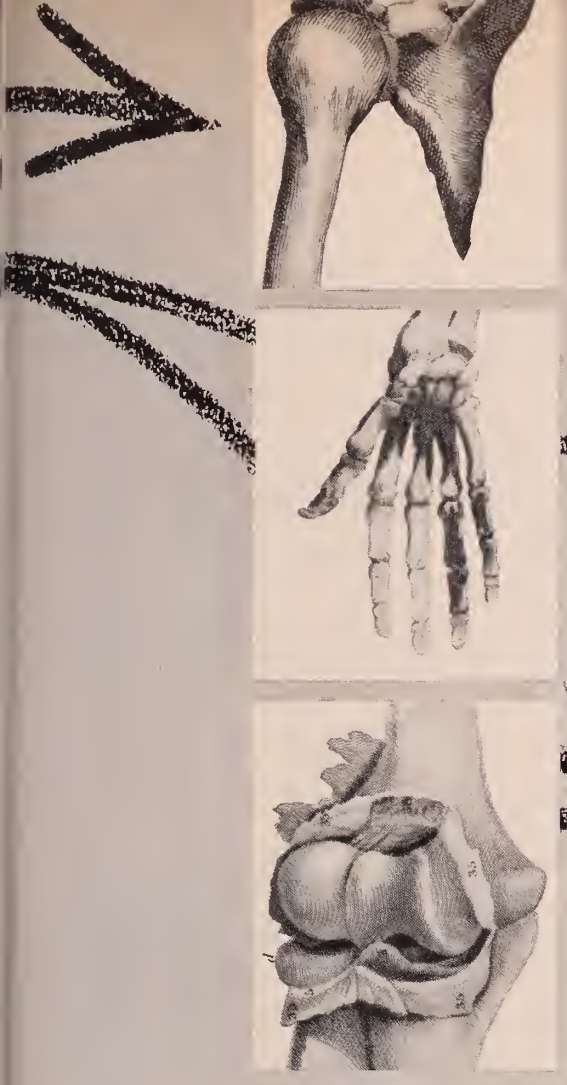
PREDNISOLONE	1 mg.
SALICYLAMIDE	5 gr.
CITRUS BIOFLAVONOID COMPOUND	33.3 mg.
ASCORBIC ACID (C)	33.3 mg.
ALUMINUM HYDROXIDE	50 mg.

Samples and literature to profession

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division of **U. S. VITAMIN CORPORATION**

250 East 43rd Street, New York 17, N. Y.





new, safer,
more comprehensive
anti-inflammatory,
antirheumatic,
analgesic

n rheumatoid arthritis, myositis, fibrositis, bursitis, and other inflammatory and rheumatoid conditions

PREDNYL affords prompt, dramatic relief from pain and muscle spasm, ncreased range of motion and often return to normal activity—because of . . .

3-way anti-inflammatory action: with potent prednisolone, water-soluble citrus bioflavonoid compound, salicylamide.

greater antirheumatic, analgesic effects: with less prednisolone and less salicylate than when either is given alone — minimizing risk of steroidism or salicylism.

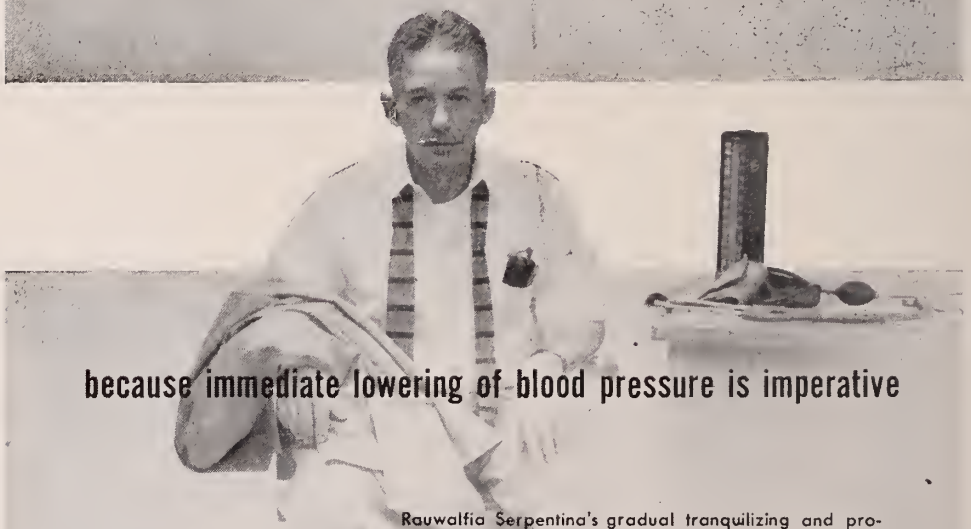
protection: against steroid-induced capillary hemorrhage, gastric distress, vitamin C depletion.

dosage: Average, 1 to 3 PREDNYL tablets q.i.d., with gradually reduced dose to effective maintenance level. Bottles of 100 and 500.

diagnosis: **hypertension, moderate to severe**

prescribed: **Rauprote***

(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protaveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasodilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which contral blood distribution and which normally prevent postural hypotension.

Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*

PHARMACEUTICALS

*Trade Mark



all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

Each* TUSSAGESIC *Tablet contains:

TRIAMINIC® . . . . . 50 mg.
(phenylpropanolamine HCl . . . . 25 mg.;
pheniramine maleate . . . . . 12.5 mg.;
pyrilamine maleate . . . . . 12.5 mg.)

Dormethan (brand of dextromethorphan HBr) . . . . . 30 mg.

Terpin hydrate . . . . . 180 mg.

APAP (N-acetyl-para-aminophenol) . 325 mg.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

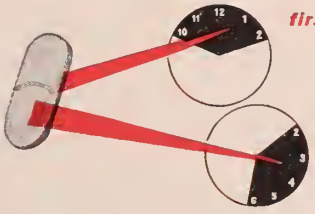
Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

To reduce upper respiratory congestion and irritating secretions.

For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

For specific, highly effective antipyresis and analgesia.



first—3 to 4 hours of relief from the outer layer

then—3 to 4 more hours of relief from the inner core

Also available—for those who prefer palatable liquid medication—

Tussagesic suspension

NEW

Tussagesic

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada



ICE MILK !

Keep fat down with Breyers Ice Milk!

- **HIGH PROTEIN VALUE!**
- **LOW CALORIE CONTENT!**

Your ice cream-loving patients will welcome this delightful, frozen treat in which Breyers famed quality flavors are blended with milk instead of cream!

Most ice creams contain 12% butterfat . . . *44% more calories than ice milk.* In some ice cream products, containing more butterfat, *caloric content is even greater!*

Breyers Ice Milk has an average butterfat content of 4%. Its use will enable your patients to enjoy a delightful, frozen treat while keeping butterfat and caloric intake substantially lower.

Available Wherever Breyers Ice Cream Is Sold.



why all the fuss over potassium?



Many physicians will recall when safe but potent organomercurials were first introduced. At the time there was considerable worry about possible potassium loss. Patients were instructed to take foods rich in this mineral, and not infrequently potassium supplements also were advised. After enough experience was gained, it became evident that only the exceptional case could lose enough potassium to be concerned about. And with oral organomercurial diuretics this was practically never a problem.

Why revive the subject now? Because clinical experience with nonmercurial diuretics indicates most of them have such a specific effect on potassium that with their use very real problems must be faced. Enough potassium loss can lead to digitalis toxicity or to a classical overt hypopotassemia. Since a fair percentage of cardiacs who receive diuretics are also digitalized, this excess potassium excretion is clinically serious. Clinical experience is still too limited with some nonmercurial diuretics to say just how often such loss will occur—but warnings already have been sounded by some clinical investigators as to the need for potassium supplementation.

Experience in many patients, for many years, demonstrates that potassium loss is never a problem when NEOHYDRIN® is the oral diuretic. And there is no refractoriness to this effective oral organomercurial.

LAKESIDE



Don't forget, Doctor—
"to take some of your own medicine!"

On vacation — at the beach — on the golf course — or gardening in your own back yard, sunburn, insect bites, cuts and abrasions are all part of the summer picture.

A handy tube of Xylocaine Ointment means prompt relief of pain, itching and burning for your patients. After you've seen to your patients' comfort, remember that tube of Xylocaine Ointment for yourself.

Just write "Xylocaine Ointment" on your Rx blank or letterhead, and we will send a supply for you and your family.

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

XYLOCAINE® OINTMENT

(brand of lidocaine*)

2.5% & 5%

SURFACE ANESTHETIC

SEE PDR

*U. S. Pat. No. 2,441,498 Made in U. S. A.

HE NEEDN'T BE HIGH-STRUNG

WEIGHT REDUCTION: Obese patients may resist dieting because they fear losing the emotional security often involved in overeating. AMBAR helps them hold the diet line by giving them a more alert, brighter outlook. **WITHOUT JITTERS:** Methamphetamine, a potent CNS augmenter, produces less cardiovascular effect than amphetamine. In AMBAR it is combined with just enough phenobarbital to prevent overstimulation. AMBAR EXTENTABS provide 10-12 hours of appetite suppression in one controlled-release, extended-action tablet: methamphetamine hydrochloride, 10.0 mg.; phenobarbital (1 gr.) 64.8 mg. AMBAR TABLETS for conventional dosage or intermittent therapy contain methamphetamine hydrochloride, 3.33 mg.; phenobarbital (⅓ gr.) 21.6 mg. A. H. ROBINS COMPANY, INC., Richmond, Virginia, Ethical Pharmaceuticals of Merit Since 1878

WEIGHT REDUCTION WITHOUT JITTERS AMBAR™ Robins

methamphetamine and phenobarbital
TABLETS AND EXTENTABS®

Now available
NEW AMBAR #2
EXTENTABS
(METHAMPHETAMINE 15 mg., PHENOBARBITAL 1 gr.)
for patients who
require higher
methamphetamine
dosage



now—an antibiotic troche that

STOPS COUGH TOO





The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

PRESCRIBE

Pentazets®

antitussive—antibiotic—anesthetic—analgesic troches

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.

whenever
he
starts
to

CHEW

he's
ready
for

Delectavites®

New vitamin-mineral supplement
in delicious chocolate-like nuggets



There's nothing easier to give
or take –
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

Each nugget contains:

Vitamin A	5,000 Units*
Vitamin D	1,000 Units†
Vitamin C	75 mg.
Vitamin E	2 Units‡
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.

Mita's

WHITE LABORATORIES, INC.,
KENILWORTH, N. J.

WHEN YOU TREAT INFECTIONS IN PATIENTS SUCH AS THESE

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- those on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin) — Sumycin plus Mycostatin

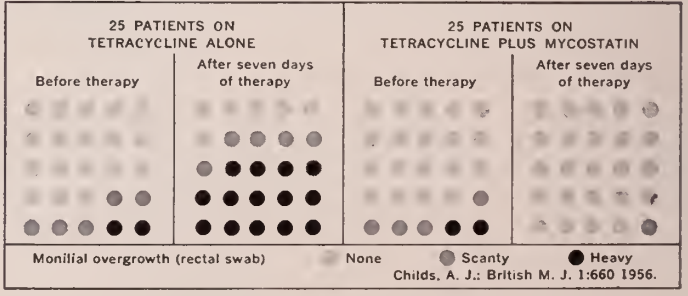
for practical purposes, Mysteclin-V is sodium-free

for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.

2. Mycostatin—the first safe antifungal antibiotic—for its specific antimonilial activity. Mycostatin protects many patients (see above) who are particularly prone to monilial complications when on broad-spectrum therapy.

MYSTECLIN-V PREVENTS MONILIAL OVERGROWTH



Childs, A. J.: British M. J. 1:660 1956.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u.), 10 cc. dropper bottles.

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Squibb Quality—the Priceless Ingredient

'MYSTECLIN,' 'MYCOSTATIN,' AND 'SUMYCIN' ARE SQUIBB TRADEMARKS



Many such hypertensives have been on Rauwiloid® for three years and more

for Rauwiloid IS better tolerated... "alseroxylon [Rauwiloid] is an antihypertensive agent of equal therapeutic efficacy to reserpine in the treatment of hypertension, but with significantly less toxicity."

Ford, R. V., and Moyer, J. H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. 23:41 (Jan.) 1958.

No Tolerance Development
Lower Incidence of Depression

Rauwiloid®

ALSEROXYLON, 2 MG.



just two tablets at bedtime

After full effect one tablet suffices

For gratifying Rauwolfia response virtually free from side actions

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When more potent drugs are needed, prescribe

Rauwiloid® + Veriloid®
alseroxylon 1 mg. and alkavervir 3 mg.
for moderate to severe hypertension.
Initial dose 1 tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium
alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.
in severe, otherwise intractable hypertension.
Initial dose ½ tablet q.i.d.

Both combinations in convenient single-tablet form.

In potentially
serious
infections..

REG U S PAT OFF
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Make new

Panalba*

Parmycin† Phosphate plus Albamycin**)

your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

forms:

Capsules, bottles of 16 and 100. Each capsule contains:

phosphate (tetracycline phosphate equivalent to tetracycline hydro- ..... 250 mg.
(as novobiocin sodium) 125 mg.

KM † Flavored Granules. When water is added to fill the bottle, teaspoonful (5 cc) contains:

(tetracycline) equivalent to tetra- hydrochloride 125 mg.
(as novobiocin calcium) 62.5 mg.
metaphosphate 100 mg.

Capsules
adult dosage is 2 capsules q.i.d.

KM Granules
treatment of moderately acute infec- in infants and children, the recom- dosage is 1 teaspoonful per 15 to lb. of body weight per day, administered 4 equal doses. Severe or prolonged require higher doses. Dosage for 2 to 4 teaspoonfuls 3 or 4 times daily, on the type and severity of the in-

Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



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Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.



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Victorian Stereo-Fidelity Radio-Fonograf plays stereo and monaural records. It features "Magic Mind" Stereo-Diskchanger, three speakers, and 15-watt amplifier, sensitive 13 tube AM-FM radio-fono combination. In hand-rubbed Mahogany. Only **$319.95**. Maple (slightly higher). Without radio **$229.95**.

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When the bronchial tree has too much "bark"

make cough MORE PRODUCTIVE, LESS DESTRUCTIVE

"Significantly superior"[2] cough therapy for "markedly" reducing the severity and frequency of coughing,[1] for increasing respiratory tract fluid,[1] for making sputum easier to raise,[3] and for relieving respiratory discomfort.[4]

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References:

1. Blanchard, K., and Ford, R. A.: Clin. Med. 3:961, 1956. **2.** Cass, L. J., and Frederik, W. S.: 2:844, 1951. **3.** Hayes, R. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956. 4. Schwartz, E., Levin, L., Leibowitz, H., and McGinn, J. P.: Am. Pract. & Digest Treat. 7:585, 1956.



ROBITUSSIN®

Robins

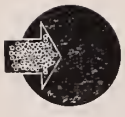
Antitussive-Demulcent-Expectorant:
Glyceryl guaiacolate 100 mg. and desoxyephedrine hydrochloride 1 mg. per 5 cc.

ROBITUSSIN® A-C

Robitussin with Antihistamine and Codeine: Same formula as Robitussin, plus prophenpyridamine maleate 7.5 mg. and codeine phosphate 10 mg. per 5 cc. (Exempt narcotic)



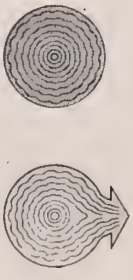
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EASES EVACUATION

*Unique encapsulation of millions of minute oil globules by Irish moss assures complete penetrant diffusion in stools.

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PROVEN SAFE...EFFECTIVE • IN PREGNANCY • IN CHILDHOOD • IN MIDDLE-AGED PATIENTS • IN ELDERLY PATIENTS • **THROUGH MORE THAN 25 YEARS OF USE**

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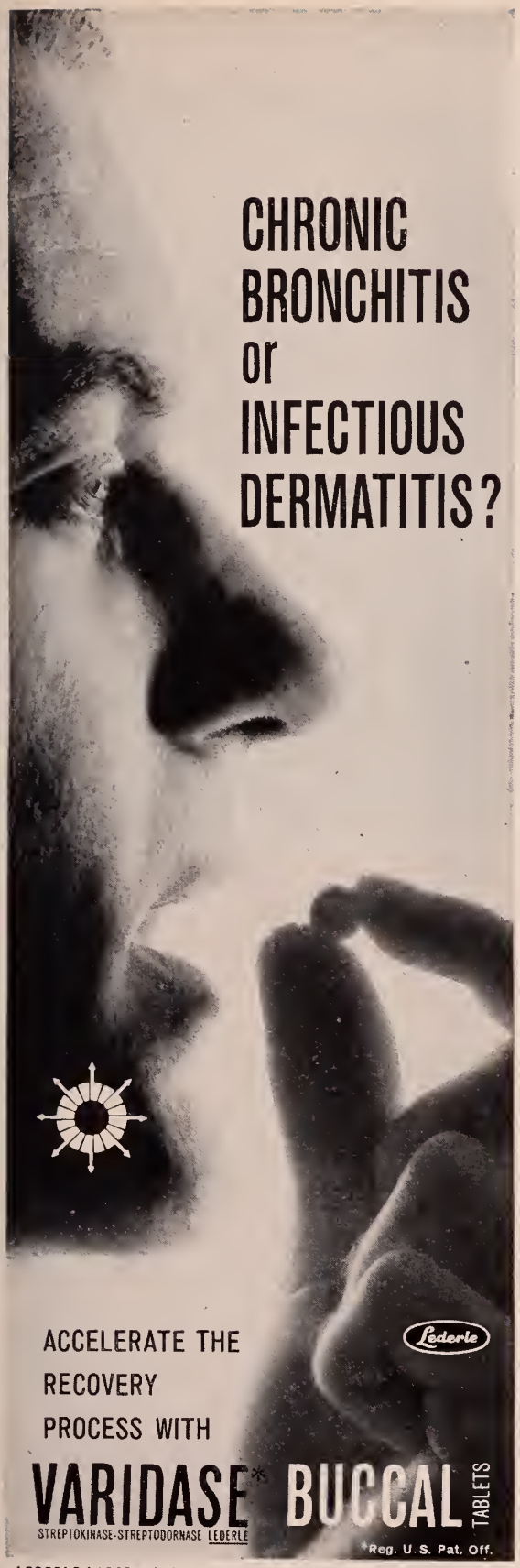
for the average patient
KONDREMUL (Plain)
containing 55% mineral oil. Bottles of 1 pint.

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KONDREMUL WITH CASCARA
0.66 Gm. non-bitter Ext. Cascara per tablespoonful.
Bottles of 14 fl.oz.

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0.13 Gm. (2.2 gr.) phenolphthalein per tablespoonful.
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NEW TRIPLE SULFA WITH THE DOUBLE PLUS

EACH TABLET CONTAINS

Sulfadiazine	100 mg.
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Sulfacetamide	100 mg.
+ Ext. Hyoscyamus (alkaloids 0.155%)	5.75 mg.
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SUPPLIED: Bottles of 100 tablets.

Superior, broad-spectrum antisepsis. Highly soluble, rapidly absorbed, maintains high g.u. concentrations. Effective in low dosage with minimal risk of crystalluria, sensitization, resistance or superinfection.

Prompt antispasmodic and anti-irritant relief of pain and urgency.

Diuresis and alkalization to enhance sulfonamide solubility and safety.

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COSA-TETRACYN

GLUCOSAMINE POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.), 2 oz. bottle

NEW! PEDIATRIC DROPS
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COSA-TETRASTATIN*

glucosamine potentiated tetracycline with nystatin

antibacterial plus added protection against monilial superinfection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn, (with 250,000 u. nystatin)

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glucosamine potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the comm
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CAPSULES (black and orange) Ea. capsule conta
Cosa-Tetracyn 125 mg. • phenacetin 120 mg. • caf
30 mg. • salicylamide 150 mg. • buclizine HCl 15

REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 8 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrov and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. M Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

thank you, doctor"



Proven in research

Highest tetracycline serum levels

Most consistently elevated serum levels

Safe, physiologic potentiation (with a natural human metabolite)

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TRICOFURON® IMPROVED

destroys all **3** *principal pathogens*

Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

℞ NEW BOX OF 24 SUPPOSITORIES WITH APPLICATOR FOR MORE PRACTICAL AND ECONOMICAL THERAPY.

NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

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to relieve edema of

DIURIL®"

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

DIURIL (Chlorothiazide) given alone to 85 patients, ". . . caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. . . . The average effective dose was found to be 1 Gm. per day by mouth. . . . The usually excellent response coupled with the absence of significant toxicity and lack of development of drug resistance makes chlorothiazide ideal for the prevention and treatment of toxemia."

DOSAGE: one or two 500 mg. tablets of DIURIL once or twice a day.

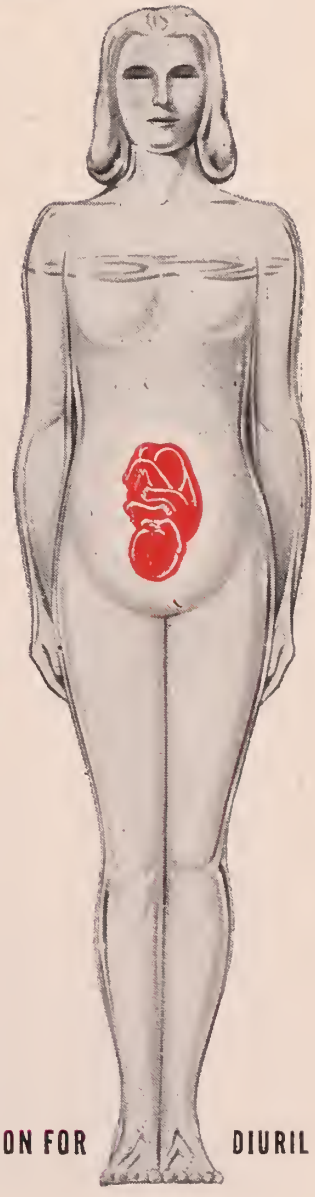
SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide); bottles of 100 and 1,000.

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....caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria...."

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A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
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PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secandory to acute troumo	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentaus strains	8	4	4	—	—
Tarticallis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusians, froctures, and muscle sareness due ta accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyasitis	8	8	—	—	—
Tarticallis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal troct and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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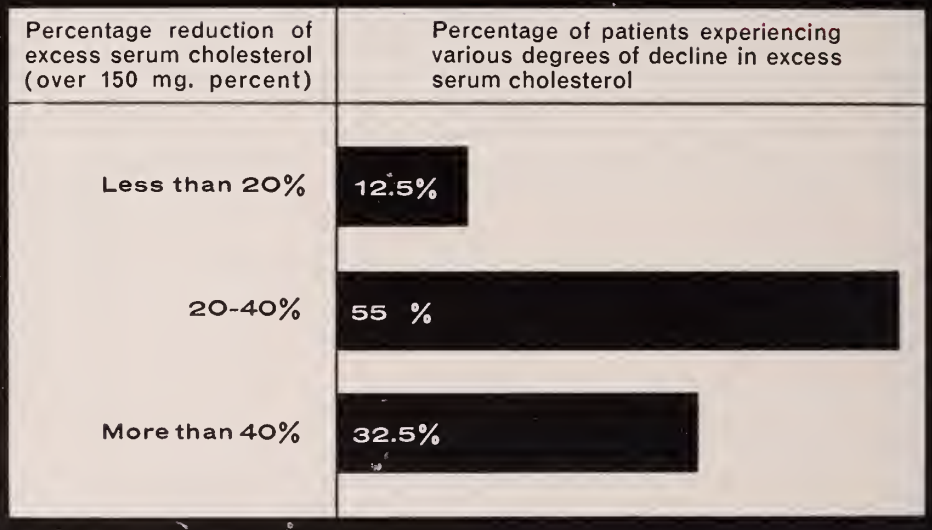
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THE JOURNAL
OF
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Editorials • • •

The Rod of Comfort

"Thy rod and thy staff they comfort me": so it is written in that most solacing and poignant of poems, the 23rd Psalm. Physicians are the lineal descendants of the priests who carried the rod and staff of comfort. And the symbol of medicine is the snake-entwined staff, the caduceus.

It seems pointless to argue whether you will take your caduceus with one snake or two. Historical theorists say that there is a difference—Aesculapius was associated with the one-serpent staff, since, legend says, he had to stamp out a snake with the stick—and the snake crawled up and entwined itself around the staff. The patient had apparently been killed by a thunderbolt. And the snake somehow revived him. Snakes were supposed to be immortal anyway—they seem to be reborn annually. When Aesculapius himself died, he became a star, still visible in the southern heavens. The astronomical name for that star is Ophiuchus: the snake-bearer.

Caduceus is a Latinization of a Greek form meaning "wand-bearer," not "snake-bearer." The reference was to the staff carried by messengers. The messenger of the gods was Mercury—or, if that is not all Greek to you, Hermes. At first he carried a simple olive branch (symbol of peace, as befits a herald who takes messages but does not take sides). One day he saw two snakes fighting. He pushed his staff between them to separate the combatants, using the olive branch again in its pacific function. The snakes crawled up the stick, glared at each other across the top of the staff, but were kept from fighting by the firm rod between them. So was born the caduceus—the two-snaked rod, which compulsively pure historians distinguish from the one-snaked staff of Aesculapius.

At any rate, it was all part of ophism—snake worship. We think of snakes as death-dealing animals as, indeed, many of them are. But snakes were associated in primitive minds with life-giving. There was the annual renaissance of the snake—or so it seemed. Primitives recognized the therapeutic power of some snake venom. Also the snake seemed magic—

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it could crawl into the earth—vanish—reappear. There were snake charmers who could do wonders with these graceful beasts. Snake dances were part of the religious ritual in many widely separated cultures. Some snakes could breath fire—these were called dragons. Snakes appear frequently in the Bible, usually under the synonym "serpent." So the snake became a symbol for fertility and shrewdness, recovery and longevity. Snakes, serpents and dragons appear in the iconography of many countries and cultures: the headdress of the Pharaohs, the flag of old China, the cult of the Hopi Indians, the cobra culture of the Buddhist and the pantheon of the Minoans—all saluting this strange animal.

Display of the caduceus as a medical insigne is relatively modern. In the U. S. civil service, specifically, the U. S. Public Health Service, the caduceus was first used just 100 years ago, in 1858. The Army did not adopt it as a medical insigne until as late as 1902. In the Navy, it is still not used to symbolize the medical officer. The A.M.A. did not incorporate it on their emblems until 1912.

Snakes are associated with healing among the Indians of America and among the Indians of India. In 19th century America, the vendor of "snake oil" as a panacea was a common part of the scene. It was usually advertised as an old Indian Snake Oil, attesting to its double potency—bearing the approval of sage folk like the Indians but also drawing some of its power from association with snakes. And the Indians of Asiatic India have, for centuries, made an extract from a snake-plant to cure madness and relieve dizziness. This plant, *Rauwolfia serpentina,* really has nothing to do with snakes except that its root looks snakey—which is what the *serpentina* means. But it inherited some of the mystery of ophism—and then, much to the surprise of modern chemists, it was found that the root really contained potent alkaloids. The best known, reserpine, displays in its name the ubiquitous serpent; re*serp*ine. It is now the current panacea, and its heritage includes the other Indian snake root, beloved by last century's American medicine men. So we come full cycle: the primitive serpent with its mythical powers of fertility, rejuvenation and shrewdness; the modern snake-root with its versatile tranquilizing and hypotensive effects; and in between the iconographic snake that entwines itself on the rod and the staff and forms the comforting symbol of the healing art.

WHO and WMA

Those symbols above are not cabalistic signs or code letters for ham radio stations. They stand, respectively, for World Health Organization and World Medical Association. As a medical society, our closer affiliation is with the World Medical Association to which our American Medical Association belongs. Furthermore, you as an individual doctor, should belong to the United States Committee of WMA. You'll find awfully good company there. You can't "belong" to World Health Organization—only governments can. There is, though, a Citizens Committee for the World Health Organization that will welcome you.

We, the most prosperous medical profession on earth should be the major supporters of WMA. Here is an organization which has done much to elevate the standards of medical care, medical practice and medical education throughout the world. It has indeed, been a powerful force in spreading to the four corners of the globe the American concept of an unfettered profession.

The World Health Organization is a worthy organization which speaks in the name of the supporting governments. The World Medical Association speaks for you. The attached chart shows, in brief, the essential features of the two organizations.

THE WORLD MEDICAL ASSOCIATION

1. WMA is an organization of national medical associations. The unit of membership is the national medical association in each country. It is completely non-governmental. It is not part of the U. N. It is a voluntary organization. AMA belongs to WMA.
2. WMA represents the practicing medical profession.
3. WMA was organized in 1947 by AMA representatives and Western European medical leaders. Purpose was to exchange medical knowledge, to protect the freedom of medicine, and promote world peace.
4. Each member association sends two delegates, two alternate delegates and observers to the General Assemblies—the supreme policy making body of WMA.
5. The executive body of WMA is the Council. This meets twice a year and comprises 11 members elected from the Assembly and the President, President-Elect and Treasurer.
6. WMA is supported by members' dues and contributions and the annual budget is about $165,000.
7. American physicians and allied corporations interested in the work of WMA are organized as the United States Committee of The World Medical Association.

THE WORLD HEALTH ORGANIZATION

1. WHO is an intergovernmental health agency. The members are the governments that accept the nine principles upon which WHO is founded.
2. WHO represents governments in their public health and medical activities.
3. WHO is the result of proposal of U. N. in 1945 to create a specialized agency to deal with all matters related to health on a world-wide scale.
4. Each member government sends three delegates, chosen preferably from the national health administration of the government, to the annual World Health Assembly.
5. The Executive Board of WHO is the executive body and consists of 18 members elected to represent 18 member governments.
6. WHO is supported by dues allocated by the U. N. scale and the budget for 1958 is $13,000,000.
7. American citizens interested in the work of WHO are organized as the Citizens' Committee for the World Health Organization.

Animal Kingdom

Presumably man is the boss animal, king of the animal kingdom. After all he rides herd on the animals who ride herd on the herds. Sheep dogs, we mean. And he gives polly a cracker, makes the pup beg for dog biscuits, feeds the cats, trains the lions, rides (or plays) the ponies, stuffs the hippo, harnesses the elephant and exterminates the bug.

Or does he? Sometimes the animal strikes back and makes man wish that Noah had not been so compulsive. No, we don't mean that the lion eats his tamer, or that the ape runs away with the fair maiden, or that the horse throws the rider. It's much more subtle than that. What we mean is that when we take animals into our homes, we also open the door to some of their diseases.

Like parrot fever. Ornithosis if you want to be fancy. This disease was dying out until the Government lifted the embargo on parrots. Overconfidence, again. And then parakeets became popular, and so did parrot fever. And to make the cynical more cynical, it is now reported that love birds are also reservoirs for the virus of psittacosis. Also ducks.

And the otherwise healthy farmer is subject to brucellosis. You don't have to go to Malta to get Malta fever. You get it from a goat or pig or cow in your uncle's back yard. They report over a thousand new cases of brucellosis every year, so sometimes man is the goat and *vice versa*.

Every day somebody is stricken with Rocky Mountain Spotted Fever. The ticks jump from rabbits or dogs and fasten themselves on *homo sapiens*—and another rickettsial disease is recorded in the books.

And finally there is man's best friend, the dog. Rover can bring rabies which, once it takes hold, is a fatal disease. Fortunately it is a rare illness—only about nine or ten cases a year being reported in human beings in this country.

With all these zoonoses around (yes, that's the right word: zoonosis in the singular, zoonoses in the pleural—nothing to do with noses), it is fitting to ask who is conquering whom?

Original Articles • • •

KENNETH E. GARDNER, M.D.
Bloomfield

Inaugural Address*

Mr. Chairman, Members of the Board of Trustees, my Fellow Officers of The Medical Society of New Jersey, distinguished Guests, Ladies and Gentlemen: With a profound awareness of the responsibility that is entailed and with a grateful appreciation of the honor that is conferred upon me by my colleagues, I have assumed the presidency of The Medical Society of New Jersey. As the 166th President of our Society and in the best traditions of my illustrious predecessors, I will consciously endeavor to advance the profession of medicine and to promote the welfare of the people of this State.

It is a personal loss to me, as I know it is to all of you, that Dr. Kump has not been spared to be with us at this convention and to be present on this platform tonight. As our immediate past-president, Dr. Kump set an inspiring example of courage and devotion to duty for all of us to follow.

The Medical Society of New Jersey was founded in 1766. It was a society before New Jersey was a state and is the oldest medical society in this country. It is dedicated to the service of a profession which is even more ancient and honorable.

Medicine is one of the oldest and most respected of the learned professions. It has been respected and honored through the ages because of its concern for, and dedication to, the welfare of mankind. Medicine was an art long before it was a science. It is still an art today, even though it may be temporarily overshadowed by the tremendous strides in all phases of scientific medical achievement and by the rapid changes in our economic, political, and social philosophies.

It is the art of medicine which makes the physician a member of a great profession, because it represents a unique personal relationship between the patient and the physician. This personal relationship is a highly individualized and specialized service in which the physician must use the art of medicine to deal with the personality of the patient, to evaluate each individual illness, and to consider his patient's occupation, his social position, his economic status, and his environment. It is the art of medicine which inspires hope, instills confidence, increases faith, promotes reassurance, and gradually encourages the will to live, for it is the art of medicine which sometimes heals when the science of medicine fails.

The science of medicine is relatively new and deals primarily with facts, figures, scientific tests, and the type of knowledge which is objective, exacting, and impersonal. It is one of the real marvels of the twentieth century and has given mankind, through scientific research, a vast store of medical knowledge which would have been inconceivable one hundred years ago. However, scientific facts alone are not enough. It is the artistic application of these scientific facts to the patient that makes the physician a true benefactor of mankind.

Modern scientific medicine had its beginning in the second half of the nineteenth century when infectious diseases were found to be due to micro-organisms. As a result of this discovery, completely new sciences of sanitation and immunology were developed. These in turn have controlled, and in some cases completely eradicated, many infectious diseases. Through the medium of vaccination, pasteurization of milk, water purification, sewage control, inspection of foods, isolation of contagious diseases, and widespread public education, the general health and welfare of our communities have been improved.

*Presented at the General Session, 192nd Annual Meeting of The Medical Society of New Jersey, May 19, 1958.

Prevention of infection by sterilization and aseptic technics, together with anesthesia, have contributed greatly to the many intricate surgical procedures which are accepted as routine today. Much has been done to eliminate childbirth infections and to bring about a progressive reduction in infant mortality.

Today many infectious diseases, such as typhoid fever, typhus fever, diphtheria, cholera, and smallpox—all tragically common fifty years ago—are seldom seen. Poliomyelitis is the most recent infectious disease to be brought under control by vaccination. Numerous infectious diseases are now readily treated by sulfa drugs and antibiotics. Many new discoveries are being made concerning vitamins, enzymes, hormones, antihistamines, tranquilizers, and anticoagulants. All of these point to a better understanding of cellular metabolism and foreshadow the eventual solution of two of medicine's great problems—the cause, prevention and treatment of malignant and degenerative diseases. With all of our new scientific knowledge, its successful application still depends upon the ability of the physician to combine the science of medicine with the art of medicine.

There is an erroneous impression that health is now a scientific commodity that can be bought, sold, transferred, or distributed by legislation or an "Act of Congress." This fails to take into consideration the fundamental principle that the practice of medicine is still an art, and as such represents a highly individualized, personal service which includes those priceless ingredients of confidence, understanding, experience, judgment, integrity, and faith. It represents the intangible factor, the quality of medical service, which cannot be legislated or included in the cost of medical care.

The student of medicine today is called upon to study and master many new subjects which were unheard of fifty years ago. His scientific training now runs the gamut from anatomy and physiology through many "ologies" to gerontology and even cosmic medicology. In spite of the vast amount of medical knowledge which is required of the average physician, a knowledge of the medical sciences and of the art of medicine is no longer sufficient to prepare him for the complex role he must play. Now he must also be a student of and conversant with the modern concepts of the social sciences—such as sociology, economics, political science and government. If he neglects these latter branches, he will be handicapped, not so much as a competent medical practitioner, but as a free citizen who must think intelligently and express his opinions clearly on current subjects. He must be constantly aware of political philosophies and proposed legislation which will infringe upon his rights as a free citizen and ultimately destroy his American heritage of liberty and justice for all.

When our country was founded, our forefathers, who drew our Declaration of Independence and our Bill of Rights, regarded as the basic privilege of all citizens the rights to life, liberty and the pursuit of happiness. With the passing of time and the development and expansion of our national economy and prosperity, the original concept of a self-reliant democracy has become radically distorted. To the politically inspired philosophy of paternalism or the all-inclusive welfare state has been added a final, all-embracing right—the right of "everyone to have everything" and its corollary "something for nothing" at government expense. In pursuing this phony philosophy we are in great danger of losing "everything for everybody"; for should statism or a paternalistic welfare state ultimately prevail, with complete control over the lives of every American, we must eventually surrender the basic rights of a free democratic people to enjoy life, liberty, and the pursuit of happiness.

Personal initiative, personal incentive, and a personal sense of responsibility for one's self and one's family are vitally essential if we are to remain free from within. Unless there is a personal sense of responsibility to provide for one's own financial future and a willingness to do a "day's work for a day's pay," the philosophy of the welfare state must eventually prevail. Trying to "get something for nothing" is a philosophy that can threaten, strain, and eventually bankrupt and destroy our entire national economy. Whenever a people lose their sense of personal responsibility for their own future and look to government to provide for them, they must of necessity become wards and dependents of the state and lose the freedom and independence which is their American heritage.

National prosperity, individual security, and the control of inflation are economic problems which are of great concern to all of us. However, they can be achieved by mutual cooperation and understanding; by increased production of all commodities; by the will to work for a reasonable wage in keeping with the cost and volume of production; by paying a fair return to the investor for the use of his capital; by the desire to produce a better product of higher quality at a lower price.

Increased production means increased wages, and better products at a lower price mean greater purchasing power.

Believing that all wages are received for services rendered—whether by the laborer, the tradesman or the executive—the medical profession, which also provides a highly trained service, believes that it has the same right to receive a fee for services rendered. However, we do not believe that needed medical care should ever be denied to anyone because of his inability to pay either in full or in part. For such a person it is agreed that the cost of medical care should be underwritten at public expense, or failing this, medical services should be supplied at reduced fees or without charge.

Make no mistake, the members of the medical profession, with genuine dedication not exceeded by any other group, want all the people of this nation to remain free and to have the highest quality of medical care available. To provide this high quality of medical care, the members of the medical profession have given unselfishly of themselves to continuous study and hard work, and by so doing have elevated the standards of medical care in the United States to a level higher than exists in any other country in the world.

As physicians and citizens, we contend that it is the right and duty of every free American citizen to provide for himself and his dependents. We contend that his earnings should not be siphoned off in soaring taxes so that he can no longer remain independent and self-sustaining. We contend that any program or legislation which tends to promote paternalism or the welfare state not only destroys the character, the dignity, and the status of the citizen as a free man, but tends to destroy the character and the integrity of our government as well. We further contend that only as long as our citizens remain self-reliant, responsible, and free will our country remain free and strong enough to survive.

That is why the members of the medical profession, who are alarmed more as thinking citizens than as physicians, look with suspicion and fear upon any type of social or welfare legislation which, in utter disregard of the economic facts, promises nebulous, superficial, and mass benefits to all in exchange for individual dignity and freedom. This is why the medical profession favors the utilization of voluntary programs to help the self-reliant citizen to defray his rightful share of the costs of the services and benefits which he wishes to enjoy. This is why we are inclined to support only such programs as would enable the government to provide for those citizens who are in genuine need and cannot provide for themselves. This is why we are convinced that proposed social and welfare legislation which involves more and more taxation to pay benefits to all persons, regardless of their need for such benefits, is a threat to the character, the prosperity and the freedom of our nation.

In the course of this convention and in the course of this symposium now to be presented, further and full consideration will be given by our distinguished speakers to many of these problems. It has been my purpose to point out that as physicians we are called upon for knowledge far greater than that which applies only to the art and science of medicine; that as physicians and citizens we are called upon to know the current social, welfare, and economic trends and to appraise critically any and all political philosophies which tend to promote paternalism or the welfare state. We must be ever alert to the effect of these political philosophies on our profession, our patients, our families, our country, ourselves as physicians and citizens, and most important of all, our self-reliant democratic way of life.

It is my hope that in the years ahead, as physicians and members of The Medical Society of New Jersey, with united strength and purpose, we will dedicate ourselves unremittingly to the performance of our duties both as physicians and citizens; and that God will give us the knowledge and foresight to make the right decisions for Medicine, for our people, and for our country. Thank you.

Bart M. James, M.D.

John A. Hunt, M.D.

East Orange

Cancers and Precancers of the Skin*

Since skin cancers are visible and accessible, a cure rate of 100 per cent is theoretically possible. Actually, the cases here reported represent an 86 per cent cure rate for squamous cell and a 90 per cent rate for basal cell epitheliomata. The ratio of cures would be higher but for the fact that patients who did not return for follow-up were counted as failures.

Never before in American medicine, has so much emphasis been given to prevention. We hear of early cancer detection on all sides. No one disputes this view. Two per cent of deaths due to cancer in the United States are attributable to cancers of the accessible oral mucous membranes and skin.[1] Over the past twenty-five years the trend has been downward. Theoretically it should be possible to reduce deaths due to skin cancer to nearly zero, since most skin cancers arise in long standing recognizable lesions. It is, therefore, essential that the lesion be diagnosed early and adequately treated both for prevention and cure.

Lesions of the skin or mucous membranes which have a tendency to become malignant are called *precanceroses*. This term should not suggest a constant sequence of benignity leading to malignancy. The word has meaning in a clinical sense. Precanceroses designates a group of lesions banded together because of common clinical, prognostic, and histopathologic features.[2] In a few cutaneous conditions such as xeroderma pigmentosum or leukoplakia, cancer probably will eventually develop. In others, such as stasis ulcers or seborrheic keratoses, epitheliomas are infrequent. The dermatologist relies on his experience to differentiate certain lesions which have been shown to possess a great capability to become carcinomatous, and those which possess this tendency to a lesser degree.

The Precanceroses

In this report, we limit the precanceroses to those lesions which most often become carcinomatous. An epithelioma develops in 20 per cent or more[3] of lesions representing the following conditions:

1. Bowen's Disease
2. The keratoses
   - Senile keratosis
   - Arsenical keratosis
   - Tar keratosis
3. X-ray or radium sequelae (Ulcerative or warty type)
4. Leukoplakia - leukokeratosis
5. Cutaneous horns

Bowen's disease is manifested by a single, well demarcated, reddish-brown lesion. If crusted, the surface below may be moist or granular. Some lesions persist for years without marked enlargement. In others squamous cell epithelioma eventuates with metastasis and death. Since the histopathologic picture is one of squamous cell epithelioma *in situ* with acanthosis, individual cell keratinization, amitotic cell division, other cellular disorders, and in-

*Read May 20, 1958 before the Dermatology Section of The Medical Society of New Jersey at its Annual Meeting.

flammatory infiltrate, many authors believe they are carcinomas from the beginning and not a precancerosis.

Keratoses are among the most frequent and common precanceroses.

Senile keratosis is seen commonly on the exposed surfaces such as the face, scalp, forearms and hands. Lesions vary in size, are only slightly elevated, circumscribed, and colored light brown to dark gray. An adherent scale is present. If the scale is removed, bleeding occurs. When definite elevation of the lesion is noted with inflammation, it may indicate proliferation and malignant change to squamous cell epithelioma. Senile keratoses usually occur in the blond, blue-eyed or freckled person who has had more than his share of sunlight or weather exposure (sailor's or farmer's skin).

Arsenical keratosis is a precancerous lesion which follows exposure to arsenic, whether this be by means of injection, the use of Fowler's solution, certain insecticides, foods, or through occupational contact. Exposure time may be months to years before keratoses or arsenical pigmentation develops. The epidermis, hair, and nails have an affinity for arsenic. The sites of predilection are the palms and soles although any portion of the cutaneous surface may be involved including the internal organs. The keratoses begin as punctate yellow to brown hard lesions on the palms and soles, and, on other portions of the skin appear as plaque-like reddish brown keratoses resembling Bowen's disease. The elemental arsenic can usually be demonstrated in excess in the epitheliomatous portion compared to that in adjacent normal skin.[4] Ultimately squamous cell carcinoma tends to develop.

According to Schwartz[5] certain substances have occupational carcinogenic properties. These are tar, paraffin, soot, pitch, creosote, anthracene, petroleum, and shale oil. Keratoses and a follicular dermatitis precede the development of industrial cancer and are most often multiple. The skin cancer is of the squamous cell variety, and appears at the site exposed to the carcinogenic agent. According to Downing[8] diesel oils, kerosene and gasoline with a low boiling point are non-carcinogenic; those of a high boiling point are potentially cancerogenic.

Ionization, radium or x-ray sequelae include the usual benign conditions such as erythema, telangiectasia, atrophy, loss of hair, mottled pigmentation and depigmentation, and the more serious warty keratoses and ulceration. The latter may appear spontaneously years after the last exposure or follow a local injury. Resultant epitheliomas are most often of the squamous cell variety, but basal cell epitheliomas can also occur according to some authors. Patients with chronic radiodermatitis should be observed every three to six months. Exposure to the sun, ultra-violet light, and further ionizing radiation must be avoided. Suitable sun screening ointments or lotions must be used for protection when in the sun.

Leukoplakia is ten times as common in men as in women.[6] Most commonly affected are the mucous membranes of the cheeks and dorsal anterior tongue. The earliest spot is milk-white or bluish-white and well outlined. The papillae of the tongue are obliterated. When there is perceptible thickening, fissuring, erosion or ulceration, treatment must be instituted. Squamous cell epithelioma develops in these thickened ulcerated patches (leukokeratoses).

Cutaneous horns or *cornu cutaneum* arise from a sebaceous cyst, wart, keratosis or scar, and are seen most frequently on the face, hands, and scalp. Most develop from a senile keratosis and histologically disclose a marked hyperkeratosis. The hyperkeratosis may have accumulated to a height of a centimeter and is dry, and gray to black in color. If squamous cell epithelioma develops it is at the base of the horn.

In the preceding paragraphs we have attempted to enumerate and briefly describe common dermatologic lesions likely to become skin cancers. These lesions are precancerous and 20 per cent or more become epitheliomas. Early recognition and adequate therapy are of prime importance in cancer prevention.

Any suspicious lesion presenting enlargement, inflammation, change in color, infiltration, or ulceration, should be biopsied. We do not believe that a biopsy causes a lesion to become malignant, hastens its growth or increases the danger of metastases. The lesion can be excised totally as an excision-biopsy, or, if only a biopsy was done and the report indicates malignancy, the follow-up treatment may be excision, electro-surgery or radiation.

MALIGNANT EPITHELIAL NEOPLASMS

MANY of the contributing factors in skin cancer are known. Some of these factors are controllable, but most of them cannot be prevented by any means now available. Blue-eyed, blond, thin-skinned individuals have the inborn tendency to develop skin cancers with greater frequency than do brown-eyed, brunette people. The deleterious effects of light on the skin of Irish, Scottish, or Nothern European persons have been substantiated. Oriental and Mediterranean races have a lesser susceptibility.[7] The Negro seldom develops a skin cancer. Most skin cancers occur on the exposed parts such as the face and hands rather than the clothed areas. This points up the role of excessive sun and weather exposure. Some dermatologists say that frequent development of skin cancer about the eyes is due to the concentration of light rays through optical lenses.

Occupation may play a part in the development of skin cancer.[8] Skin cancers are more frequent in farmers, sailors, fishermen and those in rural communities than in city dwellers and indoor workers. Tar and its derivatives have a photodynamic action on the skin. This may, in part, explain why some workers exposed to these products develop skin cancers more readily on exposed surfaces and at an early age as compared to workers in other fields.

Downing[8] does not believe a single traumatic incident can cause a skin cancer. He says that repeated injuries are necessary. We agree with this. A recent possible exception occurred in our practice. A 50-year old male of light complexion stated that he had scratched his left upper arm eight months previously. Healing took place in the normal time. Six months later he developed an elevated, pearly bordered lesion at the site of the scratch. A biopsy was done and the lesion destroyed. Pathologist's report showed it to be a basal cell epithelioma. At about the same time he developed a similar appearing new growth on the right cheek. This too, was a basal cell epithelioma. There was no knowledgeable occupational cause for this lesion. We are of the opinion that this particular individual has a proclivity to react to minor trauma with the development of epitheliomas.

The role of repeated irritation or infection of cancers is well known. For example, leukoplakia is frequent among smokers, betelnut chewers and those with ill-fitting dentures and oral infection. Skin cancers occur frequently on the thighs and abdomen from use of the Kangri-jar in India and is most probably due to frequent burns and soot. Benign, pigmented nevi may be converted into nevocarcinomas by repeated injury. Trauma to scars can cause cancer even though the latent period is years.

Cancers in those exposed to the elements are usually of the basal cell type, while those due to occupational substances are usually of the prickle cell variety.

BASAL CELL EPITHELIOMA

BASAL cell epithelioma is the most common type of skin malignancy seen in our practice. The lesion was first described by Jacob in 1827 and is known as Jacob's ulcer or rodent ulcer. In our practice, basal cell epithelioma has been seen five times as frequently as has prickle cell epithelioma. The exact statistics after at least a five-year follow-up are given in Table 1. In a report by Torrey and Levin[9] concerning 2000 epitheliomas, 70 per cent occurred on the face. Of these, 37 per cent were squamous cell epitheliomas and 63 per cent were basal cell epitheliomas. Males

are affected four times as often as are females. Basal cell epithelioma is uncommonly seen before age 30. The sites of predilection are the face and trunk; but no part of the body surface is exempt. A purely basal cell tumor rarely, if ever, develops on the mucous membrane although secondary invasion of adjacent orifices is common.

Basal cell epitheliomas are of three types—nodulo-ulcerative, pigmented, and superficial. The *nodulo-ulcerative* type usually begins as a discrete pearly papule or nodule which gradually enlarges and frequently ulcerates. The border is telangiectatic and rolled; if crusted, removal causes bleeding. Slow growth is customary. The *pigmented* basal cell epithelioma clinically appears similar to the nodulo-ulcerative type but with the addition of brown to black pigment. The pigment obscures the classic rolled pearly border and telangiectasia, and because of this, it is frequently mistaken for a nevocarcinoma and other pigmented keratoses. The third type is the *superficial* basal cell epithelioma with multiple points of origin from the epidermis. More often than not, the tumors are multiple and the trunk is a favored location. Lesions of this type are sharply marginated, flat and range in size from a few millimeters to a palm. The color is red to brown, scaly, dry, and atrophic. There is little penetration past the upper cutis for years but they are apt to become deep ulcers with invasion of the dermis.

Neglected and inadequately treated basal cell epitheliomas can cause extensive destruction of the face. Death has resulted from hemorrhage or infection in long standing cases. Occasionally a spontaneous cure occurs as a result of cicatrization after ulceration, but this is rare. According to Ormsby [3] basal cell epitheliomas are locally malignant, and they do not metastasize as such. He believes if metastasis has occurred, the lesion has changed to a baso-squamous or squamous epithelioma. However, exceptions occur and metastatic basal cell tumors have been reported. Serial sections [10] made from adjacent nodes near the epithelioma did not reveal any cell type other than that of the basal cell.[11]

BASO-SQUAMOUS EPITHELIOMA

A TRANSITIONAL tumor not infrequently seen is the baso-squamous cell epithelioma. Clinically it is impossible to differentiate a purely basal cell tumor and the baso-squamous type but the latter is likely to grow more rapidly. The microscopic picture may be misleading unless serial sections are done since one portion of the tumor may show basal-cell types and another transitional forms suggestive of prickle cells. Montgomery [4] stated that of 119 epitheliomas, 12 per cent were baso-squamous in type. Sites of predilection are the face, scalp, and occasionally mucous membranes. Metastases do occur and can lead to death. These tumors can be cured with x-rays and radium, but they are not particularly radio sensitive and recurrences are frequent.

PRICKLE CELL EPITHELIOMA

PRICKLE cell epithelioma, or squamous cell epithelioma occurs primarily or secondarily on the skin. Nearly all epitheliomas of the mucous membranes of the mouth, tongue, lips, penis and vulva are of this type. They may arise from one of the precanceroses such as senile keratoses or leukoplakia.

Evolution may be rapid with lymph channel metastases leading to a fatal termination. Prognosis is guarded. These tumors develop on the exposed surfaces of the body such as the face, lower lip, dorsal hands and forearms. In our cases of squamous epithelioma, nearly half occurred on the lower lip. The cancer begins after development of an actinic cheilitis, fissure, keratosis, or leukoplakia and in smokers.

Cutaneous prickle cell epithelioma begins as an elevated warty growth with an erythematous slightly infiltrated border. It is difficult to remove the warty hyperkeratosis. The attempt may lead to bleeding because of adherence. This characteristic of adherence differentiates a prickle cell from a basal cell epithelioma with a loose crusted top. As the lesion progresses an ulcer forms with an indurated border. Occasionally papillomatous, fungat-

ing, or vegetative growths occur which are of a low grade malignancy in distinction to the ulcerous, rapidly growing plaque of high grade malignancy. Metastases are usually discovered first in regional lymph nodes but can occur in viscera or bone.

NEVOCARCINOMA

Of all cutaneous cancers, nevocarcinoma is the most malignant and fatal. It arises from a pigmented nevus—usually junctional—or a lentigo. The junction nevus, first described by Satenstein, Traub and Keil,[13] clinically is a flat or slightly elevated, brown lesion of variable size without hair. It appears at birth or any time later on any body surface. A lentigo is a pigmented macular spot resembling a freckle and differing clinically from it by the fact that they persist and may occur on covered areas as well as those exposed to sun light. Both the junction nevus and the lentigo contain nevus cells, and, therefore may become carcinomatous. It is the junctional component of the junction nevus or the compound nevus which leads to nevocarcinoma. On the palms, soles and genitals, nevi are usually junctional and when signs of increase in size, pigment, infection, bleeding or ulceration occur, they should be totally excised. Nevocarcinomas of mucous membranes, genitals, and head and neck regions have an almost uniformly fatal prognosis.[12] If the patient survives and is successfully treated, he exhibits a proclivity to develop more primary nevocarcinomas and active junction nevi especially in the region of the primary tumor.

Biopsy or biopsy-excision must be done on nevi showing sudden or marked change. Nevocarcinoma must be differentiated from other pigmented nevi, basal cell epithelioma with pigment, granuloma pyogenicum, glomus tumor, seborrheic verruca, and single lesions of Kaposi's sarcoma.

In this report, we have not considered other epithelial skin tumors or growths such as erythroplasia of Queyrat, Paget's disease, tricho-epithelioma, or carcinomas of sebaceous or eccrine sweat glands. Mesodermal sarcomas and tumors of nerve tissue are also excluded as are the skin manifestations of the lymphoblastomas and metastatic carcinomas of the skin.

TREATMENT OF THE PRECANCEROSES

Because of the potentialities of the precanceroses we consider it advisable to eradicate lesions which show enlargement, infection, irritation, and infiltration. It is largely a matter of judgment and experience as to which lesions should be removed and by what method. If the patient is elderly and presents numerous precanceroses, it is best to observe the skin at regular intervals and remove only those lesions with obvious changes. However, if a lesion such as a senile keratosis develops on the lower lip, it should be destroyed as soon as the diagnosis is established because of the high incidence of change to a prickle-cell epithelioma.

As a rule, most superficial growths of the precancerous group can be destroyed by application of trichloracetic acid, carbon dioxide snow, curettement with application of Thorium-X; or, if deeper destruction is needed, the use of the coagulating current. If in doubt about the nature of the condition, a biopsy should be done. It is our opinion that a biopsy does not increase the danger of metastases.

TREATMENT OF SKIN MALIGNANCIES

In the treatment of malignant tumors of the skin, excellent results may be obtained by several different methods. In our series, most of the epitheliomas were treated by electrocoagulation, curettage, and x ray; and, a lesser number by excision, radium or cautery. The dermatologist is in the best position to employ any one of several methods to destroy malignant skin tumors. There are no absolute rules concerning the method. The choice of treatment should be kept flexible to insure the best results from both a functional and cosmetic standpoint.

The results of treatment are presented in the following table. Only lesions which were biopsied and followed for a period of five years or more are included.

RESULTS OF TREATMENT

THE majority of patients presenting basal cell or squamous cell epithelioma were treated by x-ray or coagulation and curettage. Desiccation is likely to cause more scarring than irradiation. When cosmetic results are of prime importance the latter method is the treatment of choice.

Fractionated doses of roentgen-ray were used and the amount of radiation at each treatment depended on the size and location of the growth. Three to six hundred roentgens were given per treatment. Our method has been to give a total of 3000 to 4200 roentgens to most basal cell epitheliomas two or three times a week in equal doses. A margin of five millimeters of uninvolved skin is included in the irradiated area about the tumor, and as improvement occurs that margin is decreased.

In general, the treatment of squamous cell epithelioma is similar except that 5400 roentgens are administered. Large, rapidly growing tumors, or those complicated by metastases should be treated by surgical removal and lymph node dissection. Surgical excision has not been used about the nose, ear, and eyelid border because of the difficulty in reconstruction and maintenance of the skin contour.

When treating an epithelioma with x-ray or radium about the eye, the eyeball should be protected by means of a small lead shield to protect the lens from late cataract and iridocyclitis. In tumors about the nose and ears the x-ray dose must be carefully calculated to prevent perichondritis and chondritis which may follow. About the ear with obvious cartilage invasion, excision by cautery or coagulation is used rather than x-ray. With excessive or high voltage radiation a painful slough may occur and require months to heal.

The statistics are presented in table form after treatment of senile keratoses, basal and squamous cell epithelioma, and nevocarcinoma. We indicate a cure rate of 90 per cent and 86 per cent for basal cell and squamous cell epithelioma respectively, with at least a 5-year follow-up. We considered that a patient who did not return for observation was a failure in a statistical sense. We are convinced the cure rate for this group would be higher except for this.

TABLE 1.

RESULTS OF TREATMENT

(All lesions biopsied)

SENILE KERATOSES

Number—205 Male—110 Female—95
Age—26 to 82 years Average—58 years
Duration—weeks to 15 years
Location—face 168 Hands, arms, legs—37
Results—cured 188
Improved—17 (no follow-up)
Biopsy: 48 disclosed early epithelioma

BASAL CELL EPITHELIOMA

Number—968 Male—518 Female—450
Age—17 to 96 years Average—59
Duration—weeks to 20 years
Location—face (832 of 968 epitheliomas)
Results—

1. Cured—859 (90%)
2. Improved or failed to return—67
3. Recurrence—42

SQUAMOUS CELL EPITHELIOMA

Number—162 Male—124 Female—38
Average age—59
Duration—weeks to 15 years
Location—lip 84 tongue 19 extremities 59
Results—

1. Cured—130 (86%)
2. No return—15
3. Death—8 (other causes)
4. Recurrence—9

NEVOCARCINOMA

Number—26 Male—18 Female—8
Age—33 to 76 years
Duration—4 days to 20 years (?)
Results—

1. Cured—8
2. Deaths—9 (referred with apparent metastases)
3. Referred for surgery—20

Eight out of twenty-six nevocarcinomas in our case histories have not recurred after a five-year period. Of these eight, none had apparent lymph node involvement at the time of treatment. Early lesions were surgically excised or removed by cautery. Of the nine deaths in the group of twenty-six, skin metastases or lymph node involvement was apparent at the time of examination. Twenty cases, including some of those later considered cured were referred for further surgery because of the possibility that lymph node involvement and metastases might be present.

SUMMARY

1. The precanceroses and common malignant epithelial neoplasms are discussed and differentiated as to etiology, location, and frequency.

2. Methods of treatment are listed and the reasons for selection of a particular modality are given.

3. A statistical follow-up of 5 years or more is given for 205 senile keratoses, 968 basal cell epitheliomas, 162 squamous cell epitheliomas, and 26 nevocarcinomas.

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Hospital Investment

The total value of the buildings, equipment, and other assets of hospitals in this country is now $13 billion, Health Information Foundation reports. This is the equivalent of $8,100 per hospital bed, $590 per hospital admission, or $78 per person in the United States.

Although hospitals belonging to nonprofit organizations have only one-fourth of the nation's hospital beds, they own almost half the total hospital assets in this country, according to Health Information Foundation. Such hospitals rank high in provision of special facilities and services.

The S. S. Tax Skyrocket

Social security tax payments are being boosted every year or two instead of at five-year intervals as originally planned. In 1954, the base was raised from $3600 to $4200. In 1956, the tax rate was increased. Now, it is proposed to raise the base rate from $4200 to $4800 beginning in 1959. Then in 1960, the tax rate is scheduled to increase ½ per cent for both employee and employer, and ¾ per cent for the self-employed. There is no way of knowing just how expensive social security "insurance" is actually going to be.

(A.M.A. Department of Public Relations)

Arthur Bernstein, M.D., *et al.*

Newark

Mephentermine in Myocardial Infarction†

Mephentermine was found to be an effective vasopressor and also an effective anti-arrhythmic agent when given in higher dose and followed by a dextrose infusion. No side effects were noted.

Cardiogenic shock (of which the shock accompanying myocardial infarction is an excellent example) is acute failure of the circulation which accompanies certain diseases of the heart and great blood vessels. In this form of shock there is a fall in cardiac output even when there is a high systemic venous pressure. Cardiac failure also frequently accompanies this. To treat this kind of shock, one must have a drug capable of causing vasoconstriction and of having a positive inotropic action on the heart muscle itself.

For many years there was great argument about the use of pressor substances because it was felt that one "must not whip a tired horse." However, the work of Prinzmetal[1] showed that, for the heart to survive, it was essential that the blood pressure be raised by one means or another. If this was not accomplished within two hours from the onset of shock, death followed.

Historically, the treatment of cardiogenic shock can be summed up by stating that two types of substances have received the widest use. First, the group of blood volume expanders was used. These included physiologic and hypertonic solutions of saline and glucose as well as whole blood, plasma, and plasma expanders. The limitations in the usefulness of these substances are self-evident, particularly when one remembers that the basic problem of myocardial insufficiency is not corrected. In fact, as has been stated above, there already may be an elevated systemic venous pressure and congestive phenomena. The second group of substances used were the pressor amines, of which neosynephrine, ephedrine, and nor-epinephrine are the best known examples. These substances more directly attack the problem through their pressor and cardiotonic effects. Up to the present, nor-epinephrine has been found to be the most effective of such agents. However, it cannot be considered as the ideal pressor substance because of (1) the necessity for dilute intravenous administration, (2) the need for very exact titration, (3) the not infrequent development of tissue slough at the site of accidental infiltration, and (4) the occasional production of cardiac arrhythmias.

Other substances generally accepted in the treatment of cardiogenic shock, which will be mentioned only in passing, are oxygen, narcotics, and digitalis, the latter being used when faced with congestive phenomena.

Our statistics[2] at the Newark Beth Israel Hospital indicate that despite the use of all

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Read before the Section on Cardiovascular Diseases, 192nd Annual Meeting of The Medical Society of New Jersey, May 20, 1958.

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these agents (except nor-epinephrine) severe cardiogenic shock led to a 95 per cent mortality.

Because of the very high mortality figures and the short-comings of nor-epinephrine, which was the best agent available to us, a search for a more ideal pressor agent was undertaken.

Our past experience with mephentermine sulfate* as a pressor agent in clinical shock and hypotension was disappointing using the dosages originally recommended. However, the recent work demonstrating the anti-arrhythmic and positive inotropic effect of the drug has stimulated us to re-examine its clinical usefulness as a pressor agent. Based on recent studies and wide experience with larger doses, chiefly by anesthesiologists, we established a new schedule of administration which would, theoretically, meet our therapeutic requirements.[3]

Mephentermine sulfate* (Wyamine®) is N-methyl phenyl butyl amine sulfate. It resembles many of the commonly used sympathomimetic amines such as amphetamine and desoxyephedrine.[4] Its pressor action is greater than that of ephedrine sulfate. In experiments[5] utilizing the perfused isolated frog heart, mephentermine was found more potent than epinephrine, nor-epinephrine, amphetamine, d-desoxyephedrine, and l-ephedrine in restoring the contractility of the depressed or hypodynamic heart. Using the strain gauge arch, other observers[6] have demonstrated the marked positive inotropic effect. This increase in the force of myocardial contraction has also been observed in man.[7]

This drug also has an anti-arrhythmic action. It protects against epinephrine-induced ventricular fibrillation[3] and terminates atrial flutter[8] due to circus movement in denervated hearts. It shortens the refractory period in all areas, increases conduction velocity, and increases the excitability of the auricle and ventricle. It seems to have no effect on myocardial tissue automaticity.[9]

This pressor, inotropic, and anti-arrhythmic action of mephentermine sulfate,* plus the fact that it can be administered by intramuscular or intravenous routes, seemed to make it worthwhile for use in the clinical states of shock seen in cardiovascular disease and other medical conditions, if a proper and practical dosage is utilized.

METHODS AND MATERIALS

PATIENTS with myocardial infarction who manifested clinical symptoms and signs of shock or who demonstrated drops of blood pressure to hypotensive levels received pressor therapy as described below. Shock was considered to be present when the patient demonstrated all or most of the following criteria: (1) blood pressure less than 80 millimeters of mercury, (2) tachycardia, (3) diaphoresis, (4) anxiety, (5) peripheral vasoconstriction with cool, clammy skin, (6) air hunger. Patients in incipient shock or those we suspected might go into shock shortly are not included in this series.

Mephentermine sulfate* was administered

*Mephentermine Sulfate was supplied as Wyamine injection®, 30 mg./c.c., by Wyeth Laboratories, Philadelphia, Pennsylvania.

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using the following dosage schedule: 45 to 60 milligrams intravenously at once followed by an infusion containing from 300 to 600 milligrams mephentermine sulfate* in 5 per cent dextrose in water. Occasionally, 45 to 60 milligrams were administered intramuscularly at once if difficulty in finding a vein was encountered. Vital signs and clinical observations of patient response were continuously recorded throughout the period of administration. Electrocardiograms were taken as frequently as deemed necessary. Patients in whom no significant or adequate response to mephentermine* occurred were then given nor-epinephrine in conventional doses. Decision to switch medication usually was made after a 20 to 30 minute trial.

RESULTS

TWENTY-FIVE patients with proved myocardial infarctions and shock were treated with mephentermine sulfate.* Sixty-four per cent (16 patients) responded with a rise in blood pressure. Unfortunately, of those who reacted with an adequate blood pressure response, only a small number ultimately survived. Actually only 24 per cent (6 cases) of the patients lived. This would indicate that the cases chosen were severe ones and not those of the mild, transient, hypotensive type. In every one of the cases the mephentermine* was discontinued for a short period at some point to be certain that there was a true response to the drug. The following are five typical case reports:

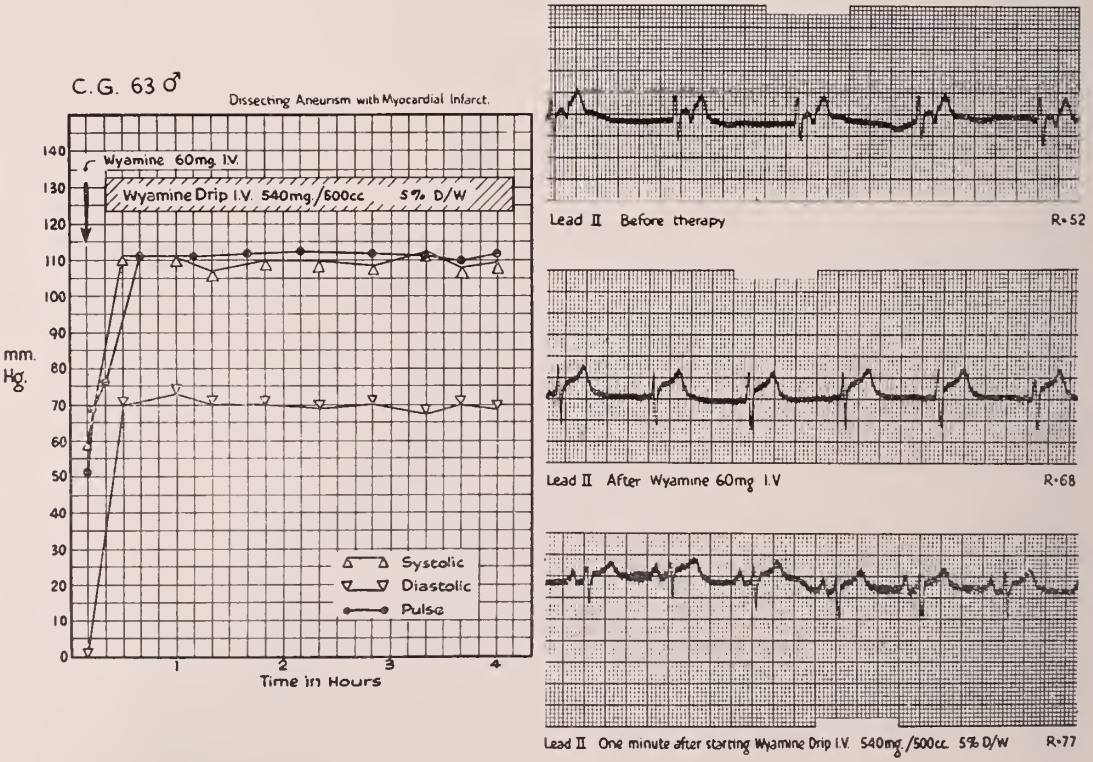


Figure 1. This demonstrates the correction of shock using first a rapid injection of 60 milligrams of mephentermine intravenously followed by a drip of 540 milligrams in 500 cubic centimeters of 5 per cent glucose in distilled water. The electrocardiograms demonstrate the conversion of a nodal rhythm to a regular sinus rhythm with mephentermine.

CASE ONE

A 63-year old male entered the hospital with complaints of severe chest pain and electrocardiographic evidence of myocardial infarction. On the tenth day he suddenly lapsed into shock with a marked slowing of the pulse. An electrocardiogram showed a nodal rhythm at a rate of 46 per minute. Sixty milligrams of mephentermine sulfate* were given intravenously at once and an intravenous infusion containing 540 milligrams of mephentermine sulfate* in 500 cubic centimeters 5 per cent glucose in water was started. His blood pressure rose to normotensive levels in 12 minutes and an electrocardiogram showed a sinus rhythm at a rate of 112 per minute (Figure 1). The mephentermine* corrected the arrhythmia before the rise in blood pressure, suggesting that its anti-arrhythmic action is independent of its vasopressor activity. This patient then did well for several days and then expired suddenly. At autopsy a recent myocardial infarction was found but the cause of death was a dissecting aneurysm of the aorta with rupture into the pericardium just above the aortic valves, causing death by cardiac tamponade.

CASE TWO

A 70-year old woman with known arteriosclerotic heart disease was admitted with a history and an electrocardiogram compatible with a diagnosis of subendocardial myocardial infarction. On the fourth hospital day, while straining on a bed pan, she suddenly developed a supraventricular tachycardia with right bundle branch block and lapsed into profound shock. She was started on mephentermine,* 600 milligrams in 5 per cent glucose in water intravenously (Figure 2). This corrected the supraventricular tachycardia and raised the blood pressure for one-half hour. When the pressure began to fall the medication was changed to nor-epinephrine. This maintained her blood pressure at normotensive levels for three hours. Meanwhile, the sinus rhythm which had been achieved with mephentermine* was maintained by rapid digitalization. She was then tried on mephentermine again, but this failed to maintain her blood pressure. When nor-epinephrine was reinstituted, it also failed to elicit a response and the patient expired.

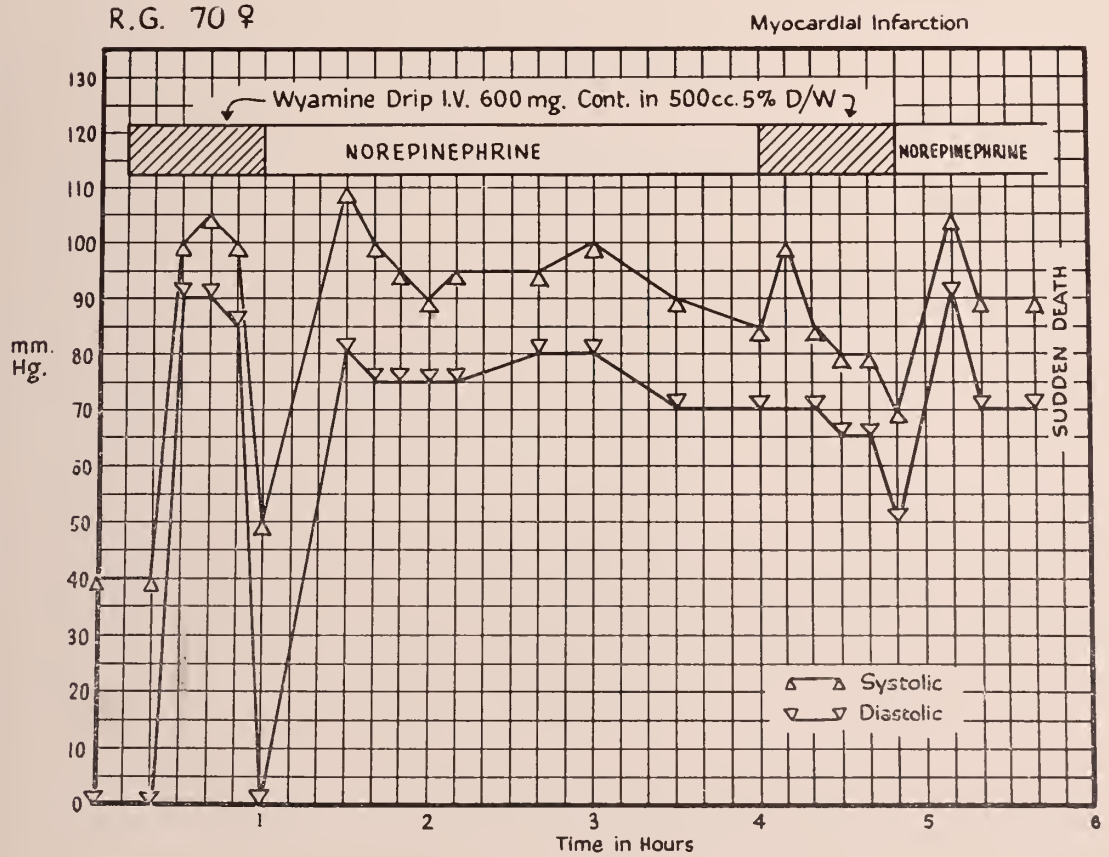


Figure 2. The mephentermine was effective in maintaining the blood pressure and relieving shock for almost an hour but it then failed. Nor-epinephrine was effective for 3 hours. Then mephentermine worked for an hour thereafter but then again became ineffective. Once more nor-epinephrine produced a response but death suddenly supervened.

CASE THREE

A 52-year old male suffered a myocardial infarction while lifting 2 crates of chickens each weighing 150 pounds. His pain continued for 24 hours before admission to the hospital. One hour after admission his blood pressure dropped suddenly from 140/80 to 90/60 and then to 76/60. At this time mephentermine* drip was started. The patient became cold and clammy within a few minutes after the blood pressure drop and developed a tachycardia and became dyspneic. His blood pressure rose rapidly to 180/110 and 140/80, and, after three hours the drip was stopped with a fall of the blood pressure to 85/70 in 15 minutes. The mephentermine* was resumed with an immediate return of the blood pressure to 120/80 where it was maintained for 5 hours. Therapy was discontinued for 2 hours with a gradual fall again to 90/50. Once more mephentermine* brought the pressure up to 130/90 but then there was a period of several hours during which the rate of flow needed speeding up to maintain blood pressure. This therapy was necessary for another 48 hours before we could withdraw the mephentermine* safely. The patient developed hallucinations during the last 24 hours of therapy but these disappeared within ten hours after cessation of the drip. He maintained a blood pressure of 120/70 thereafter and was discharged at the end of 6 weeks (Figure 3).

This case suggests the possibility that with large doses of mephentermine* there may be hallucinations whose exact cause we have not as yet been able to determine since both liver and electrolyte studies were all normal.

CASE FOUR

A 62-year old man was admitted to the hospital with a diagnosis of acute myocardial infarction. Electrocardiograms revealed changes compatible with myocardial infarction and atrial fibrillation, with an occasional ventricular premature beat. Forty minutes after admission to the hospital, the patient went into severe shock and an intravenous infusion of 600 milligrams mephentermine* in 500 cubic centimeters 5 per cent dextrose in water was initiated. Blood pressure response was obtained in minutes and the atrial fibrillation was corrected by the administration of 0.8 milligrams Lanatoside®-C. Blood pressure was maintained on the intravenous mephentermine therapy for three hours, over which period of time he received ⅔ of the infusion, or 400 milligrams mephentermine.* At this time, he developed a rapid, irregular pulse and an electrocardiogram showed ventricular fibrillation. The patient expired within minutes (Figure 4).

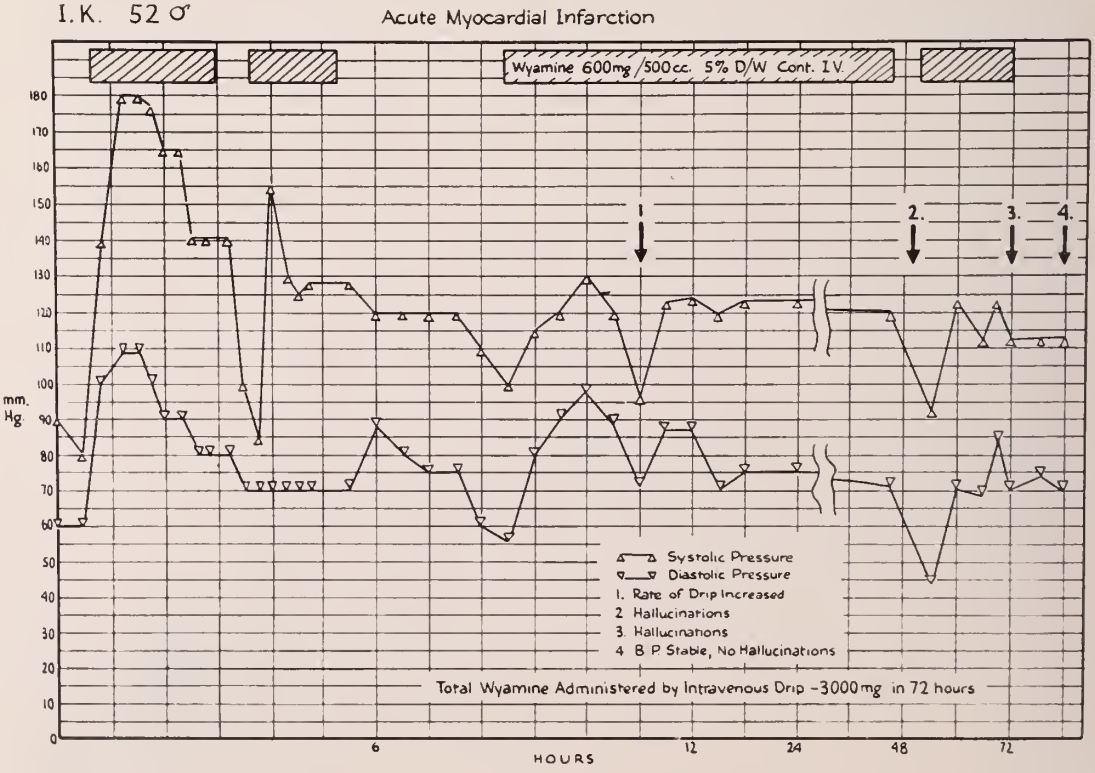


Figure 3. This patient needed mephentermine almost continuously for 72 hours to maintain his blood pressure and prevent shock. This case demonstrates well the effectiveness and safety of the drug.

CASE FIVE

A 67-year old male was admitted to the hospital with severe chest pain. He had had arteriosclerotic heart disease with angina for many years. Soon after admission, he had a convulsive seizure and went into shock. Blood pressure was unobtainable. The admission electrocardiogram revealed complete heart block. Because of the shock 60 milligrams mephentermine* was administered directly intravenously and a solution of 1200 milligrams mephentermine* in 500 cubic centimeters 5 per cent dextrose in water was started. After about 100 cubic centimeters of the intravenous infusion, or approximately 225 milligrams of mephentermine* by infusion, a second electrocardiogram revealed a conversion to sinus rhythm with first degree atrioventricular block. He failed to show any blood pressure response and expired one hour later (Figure 5).

In the therapy of these cases no cardiac arrhythmias developed from the mephentermine.* As a matter of fact, the anti-arrhythmic action is well demonstrated by these few cases. Case 1 developed a nodal tachycardia and then went into shock. When the mephentermine* was given the nodal rhythm was almost immediately converted to a sinus rhythm. Shortly thereafter the blood pressure rose and the shock was reversed. In this instance the dual value of this drug was well demonstrated. In Case 2 we were able to convert a supraventricular tachycardia to a sinus tachycardia with mephentermine,* even though we were unable to maintain the blood pressure. Case 4 demonstrates the conversion of an atrial fibrillation to a regular sinus rhythm with mephentermine* and in Case 5 a third degree block was changed into a first degree block.

In the small group of cases presented here,

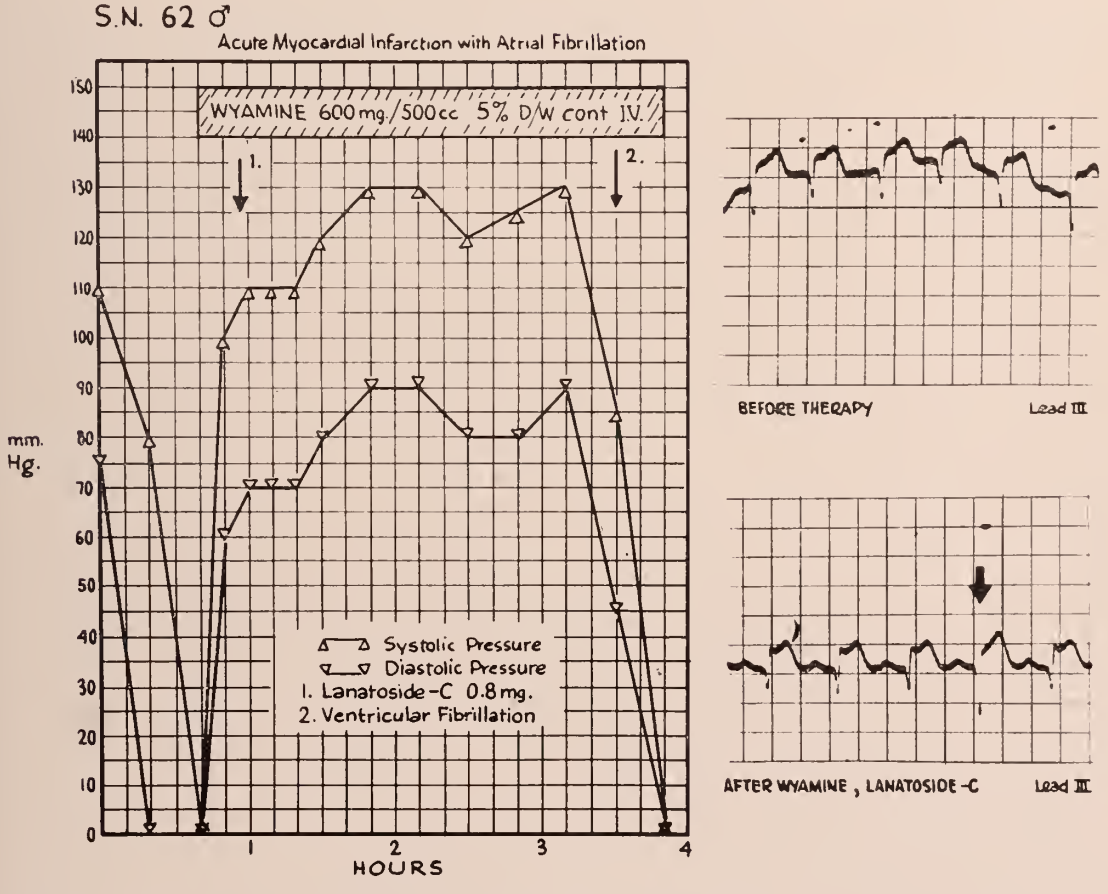


Figure 4. This patient developed atrial fibrillation after myocardial infarction. He then developed shock 40 minutes after admission to the hospital. The mephentermine corrected the shock for several hours during which time he was also digitalized. He then shows in his electrocardiograms a regular sinus rhythm. Whether this resulted from the mephentermine, the digitalization, correction of anoxia or a combination of these factors cannot be stated with certainty.

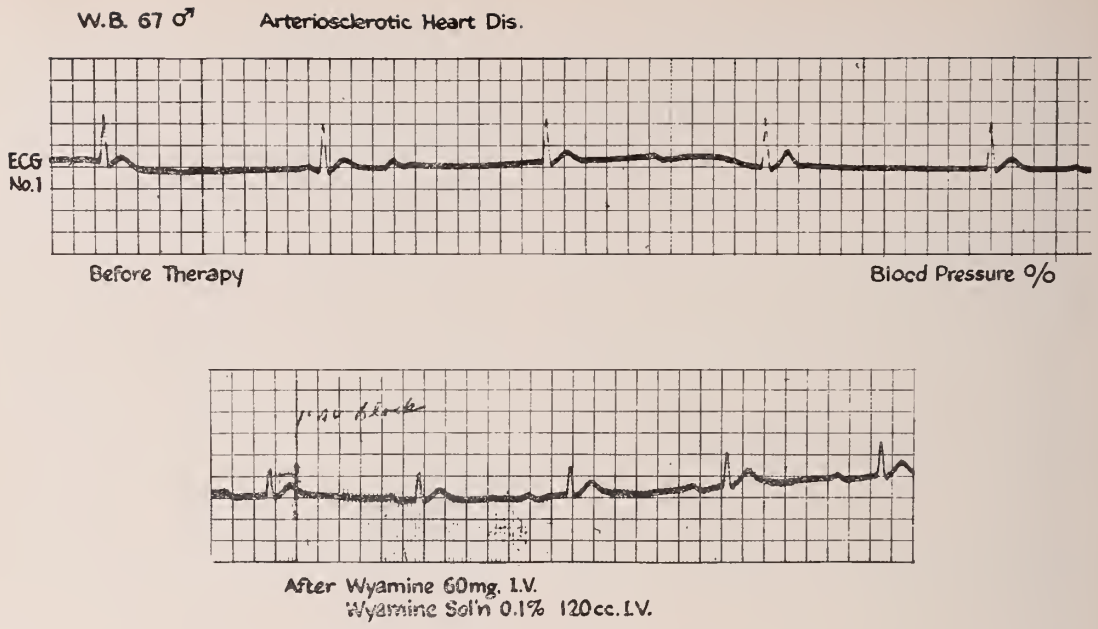


Figure 5. These electrocardiograms show the change from complete heart block to first degree block during therapy with mephentermine. Since there was no significant rise in blood pressure we must consider this to be the result of direct mephentermine anti-arrhythmic action.

the varied advantages of mephentermine* have been well demonstrated. It seems to us that in the doses used we have found a pressor substance that is not only valuable in the therapy of shock, but has other worthwhile effects. Its anti-arrhythmic activity was well demonstrated in the cases presented. The arrhythmias were corrected before the rise in blood pressure occurred, indicating that anti-arrhythmic activity resulted from the direct action of the mephentermine* rather than from the correction of anoxia by a rise in blood pressure. This is a most valuable attribute in any drug and is certainly most desirable in a vasopressor substance.

The need for intropic activity in the correction of cardiogenic shock has been emphasized on many occasions. Though we have not been able definitely to demonstrate this ability in our studies, there is good suggestive evidence in that in almost every case, when mephentermine* failed, the vasopressor nor-epinephrine was also ineffective. This then is one more reason we feel that this substance is most valuable in the treatment of shock associated with myocardial infarction.

The blood pressure response, when achieved, was accomplished in from 5 to 60 minutes in this group of cases without the need for careful titration demanded by nor-epinephrine. Further, in no case did a slough or any local reaction develop at the site of infiltration. This is a most important and desirable attribute.

In addition to the intropic (cardiotonic) action of mephentermine* there is also evidence that there is some effective vasoconstriction. This is not of nearly the same degree as that of nor-epinephrine but it must be noted that only rarely in this group was the latter effective when mephentermine* failed. This would suggest that the mephentermine* was wholly adequate in this category, as well. This was further borne out by some of our previous studies which showed that mephentermine* was effective in treating shock of hemorrhage and peritonitis as well.[10]

The fact that mephentermine* can be given intramuscularly or as an injection intraven-

10. Bernstein, A., Cohen, F., Robins, B., Simon, F.: The Treatment of Arrhythmias and Shock with Mephentermine Sulfate in Large Doses. J. Newark Beth Israel Hospital, 9:3 (1958).

ously is another great advantage. The physician is thereby enabled to give the patient in shock immediate therapy in the acute emergency or tide him over until an intravenous drip can be set up and started or the patient can be transported to the hospital for further treatment.

SUMMARY

MEPHENTERMINE* produced an effective rise in blood pressure in 16 cases of shock accompanying myocardial infarction, and corrected various arrhythmias. Although shock was successfully treated, 10 patients eventually died, pointing to the severity of the infarction in these cases. There were only six survivals, emphasizing again the seriousness of the problem of cardiogenic shock. We conclude that mephentermine* is an effective vasopressor as well as an anti-arrhythmic agent in the higher dosage (45 to 60 milligrams, intramuscularly or intravenously) followed by an infusion of 600 milligrams in 500 cubic centimeters 5 per cent dextrose in water used by us. The further potential of this drug should be investigated in a larger series for ultimate confirmation of the excellent results suggested by these studies.

CONCLUSIONS

1. Mephentermine* sulfate can be given intramuscularly or intravenously in doses of 60 milligrams to the patient in cardiogenic shock.
2. An intravenous drip of 600 milligrams of mephentermine* in 500 cubic centimeters of 5 per cent glucose in distilled water was able to raise the blood pressure of 16 of 25 patients with myocardial infarction in shock.
3. There was survival in 6 cases, *i.e.*, 24 per cent.
4. Mephentermine* was effective in correcting arrhythmias such as atrial fibrillation, nodal tachycardia and heart block in patients with myocardial infarction.
5. Mephentermine* also has intropic and vasoconstrictive action.
6. No sloughs, side effects nor need for careful titration was noted with mephentermine.*

201 Lyons Avenue

Stop Baby's Crying!

The era of letting babies "cry it out" is over, states a bulletin from the Minnesota Medical Association.* Minnesota doctors now advise treating and accepting young babies as "very human beings with justifiable demands to be met and unquestionable needs to be filled." Babies cry less when they are cared for more. "Having his mother around him, being handled and fondled by her not only reduces the baby's need to cry but has strong positive effects on his health and emotional development as well."

It is not good to allow a young baby to "cry it out." The crying fit is not good for him; it causes disagreeable sensations, perhaps even pains and can end in complete exhaustion.

Some parents fear that the attentions given a crying child may spoil him and may make the attention a habit. This is not so. "The baby whose physical needs have been supplied, who has received adequate mothering and love actually requires less and less of such attention as he grows older."

*Minnesota Medicine 40:35 (Sept.) 1957

Alfred Bronner, M.D.

Passaic

Observations on Iproniazid (Marsilid®) Therapy in Ambulatory Psychiatric Patients

Iproniazid appears to be an effective antidepressant in two out of three depressed patients. However, as Dr. Bronner here points out, the drug has numerous side effects, and cannot be given unless the patient can be closely supervised. It is considerably slower than the electroshock therapies in its time of action.

The treatment of depression, like that of anxiety and agitation remains a challenge to the clinician. Until the advent of iproniazid, the principal tool for combating depression was electrotherapy. If that failed further therapeutic attempts produced little, if any, results.

The present report deals with 30 private patients in whom depression was an outstanding symptom. Most of them had been previously treated by both psychotherapy and medication or had had electroshock therapy. Now iproniazid was given in an attempt to influence a symptom that had not yielded to any other approach. Iproniazid was the main and initial treatment for only three patients in this group. Concomitant psychotherapy was used wherever indicated, although some of the most remarkable improvements occurred without formal psychotherapy, in patients in the involutional age group.

This program was begun in my office in April, 1957. One of the patients is still on the drug 10 months later. The majority of the patients have been under observation for 3 to 4 months. One died one week after the drug had been discontinued. She had been treated successfully with electroshock therapy for an uncomplicated psychotic depression one and a half years prior to her death. Because of a recurrence of her depression, she was started on iproniazid, 50 milligrams three times a day. The drug was discontinued after one week because she was unimproved and the family pressed for more active treatment. She was scheduled for electrotherapy after a waiting period of a week. Before treatment could be started the patient became suddenly ill with severe headaches. Within a short time she began to vomit and lost consciousness, lapsing into a deep coma within a few hours. She died three days later in the hospital after having been kept alive with artificial respiration. A spinal tap was grossly bloody. The diagnosis of spontaneous subarachnoid hemorrhage was confirmed at autopsy. Since the patient weighed 65 kilograms the dosage was 2.3 mg/kg. Duration of treatment was only one week. Blood pressure had remained at 140/90. There were no neurologic signs present at the end of the week. Death must be considered coincidental and unrelated to iproniazid.

FAILURES

THE above mentioned patient is included in the ten who are listed here as treatment failures. This represents a third of our cases. Four of these "failures" had a trial period of 4 weeks or more on the drug. In the others, the drug was discontinued because of annoying side effects and lack of improvement. Three might have benefited from longer administration, but this was considered unsafe since it was impossible to supervise the patient closely enough. Five of the ten patients suffered from recurrent depressions, all of which had started after the age of 30. Three of the five also had a great deal of overt anxiety. The clinical diagnosis was manic-depressive psychosis, depressed, except for one in an agitated involutional depression. They all had responded well to previous electroconvulsive therapy. The other five patients belonged in the schizophrenic group. Three had been frankly psychotic and two were "pseudoneurotic." One chronic schizophrenic patient was told to discontinue the medication because she complained of "not knowing what she was doing." Since she had had similar episodes before, this could not be clearly ascribed to the drug. However, I did not want to risk the chance of producing a full-blown toxic psychotic episode. In one schizophrenic patient it was doubtful whether he had taken the medication and his lack of improvement could not be clearly judged a treatment failure. Four in this group had previously received electroshock therapy. Three had shown only partial or short lived responses to this treatment. The fourth had been successfully treated by electroshock one and a half years ago, but had refused the same therapy for her present primarily depressive episode. Treatment duration varied from one to eight weeks in the failure group.

As a rule treatment was stopped when there was obvious lack of progress or side effects were too distressing or threatening to the patient. It appears from this small group that there is no correlation between success or failure with electric shock therapy or with iproniazid. The same negative conclusions could be drawn from the treatment successes with iproniazid. There, too, it was impossible to predict improvement with the drug on the basis of previous response to electroshock.

SUCCESSFUL CASES

IN EIGHTEEN of the thirty patients treatment was considered successful. This represents 60 per cent of the patients reported on. Success or failure were determined by clinical observation consisting of the patient's self evaluation, facts perceived through interview and reports from the family, whenever available. Only a clear-cut spontaneous declaration of improvement by the patient corroborated by observable improved performance was considered a treatment success. Improvement was all the more significant since the great majority of the improved patients had failed to respond to psychotherapy, electroshock therapy and other drugs. Where drug therapy, usually consisting of a tranquilizer with an amphetamine or methylphenidate, had previously been inadequate there was a distinct improvement following the administration of iproniazid. The patients in the successful group were equally divided between 9 in the depressed and 9 in the schizoid-schizophrenic group. Of the depressed, all were of involutional age. Four were agitated depressives. Five of the nine depressed patients had had at least two courses of electroshock therapy, responding much less to the second course with a tendency to relapse. They refused further electroshock treatment and were therefore placed on iproniazid. Of the remaining four, three would have needed electroshock treatment had it not been for the use of iproniazid. In the schizophrenic group there were three postpartum psychoses, two of whom had been ill for several years but maintained at home with supportive psychotherapy and medication. All three had had electroshock therapy with only temporary or poor results. The other six were borderline patients with a strong depressive trend.

DOSAGE AND DURATION

THIS drug had been well studied in the treatment of human tuberculosis. An initial dosage of 150 milligrams a day was considered safe and seemed therapeutically effective in most cases. However, with the wider use of the drug, side effects appeared even on this dosage so that the initial amount of medication may have to be reduced to 100 milligrams a day in divided dosage. The severity of the depression, anticipated hypotension in patients with low blood pressure, and the presence of cardiovascular disease should be considered in selecting the starting dosage.

Other side-reactions cannot be anticipated but must be watched for by close supervision of the patient. In the beginning phases of treatment and until a maintenance dosage has been established, it is well to see the patient at least once a week. The patient is also instructed to call the physician if in doubt about the dosage or if he has any unusual sensation. He is forewarned that some 'lightheadedness' may occur. Before starting treatment the patient's weight, blood pressure and deep tendon reflexes should be noted. This is reviewed at weekly intervals. It soon becomes clear that certain patients are prone to changes in blood pressure and neurotoxic reaction. The routine should be modified accordingly.

Since iproniazid excretion is slow, the initial high dosage can be reduced as soon as improvement occurs. *Earliest possible reduction of dosage is mandatory, because of possible toxic reaction.* Since the drug builds up slowly to an effective level, the first signs of improvement may be slow in coming. It is, therefore, wise to continue for several weeks with the medication before discontinuing it as ineffective. In the present series one patient felt better after three days, and one patient took six weeks before distinct improvement was noted. There seemed to be a direct relationship between the severity of the depression, the amount of medication needed and the time necessary before improvement could be noted. After improvement occurred, cautious reduction of dosage was started. Depending upon the severity of the initial complaint, reduction by a one-fourth or one-third of the starting dose was made. Reduction of the dosage was continued until the patient was able to maintain his improvement with the smallest amount of medication. In the present series maintenance doses varied from 10 to 100 milligrams per day. In some patients where dosage was reduced too quickly, patients showed signs of relapse only a week or ten days later. However, an adequate increase in medication completely reversed this trend.

All but one of the improved patients is still on the drug. One has been on iproniazid for ten months; the majority for four months. It will be impossible to tell how many will still need the medication at the end of a year. However, it seems that just as the phenothiazines check psychosis and agitation, so iproniazid checks depression. If the process is chronic the drug may have to be used for long periods of time. In acute episodes, short term use may be possible. Half of the improved cases in the present series have been ill for over a year and lengthy use of iproniazid can be expected. The one patient no longer on the drug showed moderate depression of recent onset. A previous depression had been successfully treated with electroshock.

TOXICITY

SELIKOFF and Robitzek[1] reported extensively on the use of isoniazid (Rimifon®) and iproniazid (Marsilid®) in tuberculous patients. While both are considered effective antituberculous agents, iproniazid is the more toxic of the two. There appeared to be a direct relationship between increased dosage and increased side effects. A case of fatal toxic encephalitis is reported by Mitchell[2] after six months' treatment with iproniazid (4-5 mg/kg of body weight). He quotes evidence that isoniazid and iproniazid displace the nicotinamide essential in cellular metabolism. Selikoff[1] feels that the 2 mg/kg dosage

1. Robitzek, E. H. *et al.*: Diseases of the Chest, 23:23 (Jan. 1953).
2. Mitchell, R. S.: Annals of Internal Medicine, 42:42 (February 1955).

is safe. In ambulatory psychiatric usage a higher dosage should, if possible, be avoided. However, with psychiatric usage a large number of patients will be treated with the drug and many more people with individual sensitivity will be reached. Close supervision of patients on the drug appears the best method of avoiding serious side effects. Selikoff and Robitzek[3] list the following symptoms of toxicity: (1) Vertigo, (2) Constipation, (3) Twitching of lower extremities, (4) Drowsiness, (5) Insomnia, (6) Headache, (7) Weakness of legs, (8) Disturbed vision, (9) Hyperreflexia, (10) Delay of Starting Stream, (11) Tinnitus, (12) Dryness of mouth, (13) Skin rash, (14) Exertional dyspnea. All but numbers 3, 8, 11, and 13 were encountered in the present series. Two patients reported a very disagreeable taste following drug intake. True vertigo (rotatory dizziness) occurred in one patient. It responded promptly to reduction of dosage of Marsilid® and administration of Bonadoxin® (Bonamine® plus pyridoxine). This patient also showed hypotension with symptoms of lightheadedness occurring when the systolic pressure went below 85. Whether the vertigo represented neuropathy of the eighth nerve or a vasomotor phenomenon was not clear. The same patient also showed weakness in the legs and inability to walk for any distance. There were no reflex changes or tenderness of nerve trunks in this patient. Daily administration of 50 milligrams of pyridoxine abolished this side effect completely. Carlson *et al.*[4] used pyridoxine for the treatment of isoniazid neuropathy in dosages of 25 to 200 milligrams per day, with the majority not needing more than 50. Neuropathy is not a contraindication to the use of the drug. Constipation was a common problem, but not a serious one. One patient had a mild fecal impaction. However, attention of the patient must be directed to proper bowel habits. In one other patient the oral administration of neostigmine 15 milligrams three times a day for several days corrected the constipation.

No serious impotence or other sexual disturbances ascribable to iproniazid were found in this group, except for one male depressed patient who complained of lack of libido. A more serious side effect was pitting ankle edema in three patients. All three had been on the drug for more than two months. They had no previous cardiac or renal disease. They had no difficulty in urinating or starting the urinary stream, but were aware of passing less urine. All three are still under observation. They are being treated with Chlorothiazide®, a diuretic, and a reduction of iproniazid dosage. One patient showed a moderate increase in urea nitrogen. The urines in all three patients were normal. It is not clear whether the edema is an absolute contraindication to the drug.

Increase of appetite and weight gain were welcome signs for most of the depressed patients who responded well. Clinical improvement did not always run parallel with a corresponding weight gain. However, none of the treatment failures showed a weight gain or distinct increase in appetite. In an interesting study of the effect of isoniazid and iproniazid on the appetite of non-tuberculous patients, Hollander[5] concluded that the effect was due to the supression of toxicity rather than a specific primary appetite stimulation. In psychiatric patients the reduction of the symptoms of anxiety and depression allow for better eating. With chlorpromazine many patients show similiar increase in appetite and considerable weight gains, apparently due to the reduction in anxiety.

CONCOMITANT TREATMENT

Most of the patients in the present series were also receiving other medications. Many had been receiving a combination of a phenothiazine and amphetamine for the control of anxiety and depression. Iproniazid was added to the other medications. The amphetamines were gradually reduced as the depression improved with iproniazid. At times it was necessary to continue using a smaller dos-

3. Selikoff, I. J. and Robitzek, E. H.: Diseases of the Chest, 21:121 (April 1952).

4. Carlson, H. B. *et al.*: New England Journal of Medicine, 255:118 (May 1956).

5. Hollander, G. A.: Diseases of the Chest, 24:27 (January 1955).

age of amphetamines in combination with iproniazid, since the latter could not be pushed to the fullest because of its side effects. Iproniazid combined well with the phenothiazines where indicated. It was also possible to reduce those too in many instances. Intravenous use of sympathomimetic drugs with iproniazid appears contraindicated, since serious precordial distress and cardiac embarrassment have been reported. However, it combines well with intravenous barbiturates. In one patient the use of oral amphetamine with iproniazid produced severe headaches and vomiting which promptly stopped as both drugs were discontinued. The patient had never responded in that fashion to amphetamines alone. This particular reaction seemed the exception rather than the rule, since it was not found present in any of the other patients.

Electroshock therapy has not been displaced by iproniazid, but will be further restricted as iproniazid is used more widely. We now have a choice as to which treatment to use for psychotic depression. A recent suicidal attempt or strong suicidal preoccupations should be treated by electroshock therapy since a quicker and more dependable response can be expected. However, if there are physical contraindications and proper supervision of the patient by his family is possible, iproniazid may be used. In psychotic depressions of milder intensity a trial with iproniazid is indicated. If the patient does not respond or cannot tolerate therapeutic doses of the drug, then electroshock therapy may have to be used. Concomitant use of iproniazid and electroshock is probably risky.

Because of its hypotensive effect cardiovascular accidents may occur in combination with electroshock. An arbitrary waiting period of one week is considered safe by the author to start electroshock after discontinuing iproniazid. When the blood pressure returns to normal sooner, especially if only small doses of iproniazid had been used, electroshock therapy can be started safely. In one patient in this series electroshock therapy was started without difficulty only four days after withdrawal of iproniazid.

Iproniazid should not be used in milder and primarily neurotic depressions. The indications for iproniazid should be considered on the same basis as the indications for electroshock therapy. In the present series psychotherapy of a more formal nature was possible after an improvement with the drug had occurred similar to that which occurs when a phenothiazine reduces agitation and normalizes thinking. In some patients where side effects prevailed, there was a tendency on the part of these patients to spend too much time on physical problems; however, it was always possible to guide the patient properly. Intensity and depth of psychotherapy varied with the patients' needs and basic ego strength. Magical expectations and defensive maneuvers involving the medication could easily be recognized and interpreted to the patient. Most patients in the present series were not able to benefit from therapy touching on deeper psychodynamics. Where motivation towards a psychotherapeutic exploration of problems existed it was not disturbed by the improvement with iproniazid. Frequently the general improvement made such an investigation possible. Where motivation was lacking, or resistances were too great, the clinical improvement seemed to reinforce opposition to a more formal psychotherapy.

SUMMARY

Iproniazid is a remarkable antidepressant drug. Its effect repeats the results of electroshock therapy in many patients. Its indications are the same as electroshock therapy. The choice depends on the patient's needs. Its limitations are disagreeable side effects, the need for constant supervision while on the drug, and, often, the slowness of its action. Further experience with the drug is needed before more definitive conclusions can be reached. The area of its toxicity needs further study as do its effects and the effectiveness of long term treatment.

53 Passaic Avenue

Eva Topkins Brodkin, M.D

Newark

The Physician's Responsibility in the Care of the Skin*

Physicians have too long abandoned skin care to the beauty parlor, the barber, the lay-advertised cosmetic or ointment. Preventive dermatology is a proper field for medical practice. And Dr. Brodkin here points out many practical little ways in which the family doctor can help.

The skin varying with age, race, occupation and climate must be given proper care to remain healthy. The physician should advise precautions for the patient with excessively dry or abnormally oily skin because the former is predisposed to winter itch, bath pruritis and eczema; the latter, to seborrheic dermatitis, acne vulgaris, acne rosacea and alpoecia.

The skin of the infant and young child is usually dry since little sebum is produced until puberty, when the sebaceous glands are stimulated by the androgens to greater activity. The quantum of sebum then remains constant until it regresses with the degenerative processes of age when the skin becomes thin, dry and often scaly.

A woman distressed to see wrinkles appearing on her face may inquire about hormone creams. This is a controversial subject but the consensus among experienced investigators [1] is that the commercial cream containing from 7500 to 10,000 international units of estrogen per ounce causes no ill effects [3] locally or systemically provided not more than 50,000 units are applied within a month.[4] With regular use of this cream, the skin improved in appearance. Sections examined microscopically showed thickening of the epidermis and plumping of the collagen fibers. The changes took place only in the post-menopausal woman. It was not found in any of the younger women with normal ovarian function. If directions on the label are closely followed no harm and some benefit may result; still the doctor should not recommend these creams indiscriminately.

One major factor causing dryness of the skin is dehydration of the stratum corneum, which receives its water from both endogenous and exogenous sources. The endogenous water comes not only from the sweat, actively secreted on the surface of the skin, but also from water diffused into the epidermis from the cutis.[2] This diffused water is prevented from reaching the surface by a barrier located in the epidermis somewhere below the horny layer. The exogenous water is derived from the environment.

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*Read May 20, 1958 before the dermatology section at the Annual Meeting of The Medical Society of New Jersey.

1. Eller, Joseph: Archives of Dermatology, 59:449 (April 1949).
2. Ormsby, D. and Montgomery, W.: Textbook of Dermatology, Philadelphia 1954. Lea and Febiger. P. 58.
3. Peck, S. M. and Klarmann, E. G.: The Practitioner, 173:159 (August) 1954.
4. Goldzierher, Max: Hormones in Cosmetics. Interscience Publishers. New York, 1958.

If water is lost from the surface more rapidly than it reaches there or if the relative humidity is less than 60 per cent and the epidermis is not being hydrated by active sweating, dehydration of the stratum corneum results and clinically we have a skin that is flaky and rough, inflexible, hard and fissured in spite of any natural oil it may contain.

THE "acid mantle," the protective layer on the surface of the skin, is composed of the horny layer of the epidermis together with the sebum and the sweat. All these elements, particularly the sweat, contribute to its acidity. This probably explains "winter itch"—there is less sweat and therefore a diminished acidity of the skin. In addition, there is exogenous material from the environment lying on and mixed with the normal secretions of the skin. This layer not only protects the skin from pathogens but is indispensable to its health.[5]

The exogenous as well as the autochthonous material must be removed for sanitary and esthetic reasons. There is no more pleasant way to accomplish this than with soap and water. When the ordinary soap is dissolved in water, it becomes ionized and partly hydrolyzed with the formation of free alkali. The resulting akaline solution reduces the acidity of the skin and it takes several hours to restore the normal pH which averages about 5.5. On long immersion of the skin in such a solution, there is swelling and some debridement of the horny layer of the epidermis. While the normal skin apparently suffers no ill effects from ordinary exposure to soapy water, damage will result if it is washed too frequently, not rinsed properly or immersed in a soapy solution for long periods of time. In addition, the skin is defatted by the removal of sebum.

Over-exposure of the skin to alkalies and defatting substances, exposure in winter to the cold wind outdoors, and to low humidity of overheated rooms indoors will cause xerosis or asteatosis. This is manifested by excessive dryness of the skin and if the causal factors are not removed at this point redness, scaling and eventually fissuring may develop. Systemically, xerosis is found in hypovitaminosis A, hypothyroidism, and in disorders where there is a disturbance of the water balance, as in wasting diseases and toxemias. In these cases the underlying cause must be corrected.

Ichthyosis, unlike xerosis, is an inherited disorder and is characterized by a drier skin. The extreme dryness of the skin varies from the "harlequin fetus" to much less severe generalized or localized forms. In its less severe form, it is recognized by its dry, harsh scaling which is caused by abnormal cornification. The sebaceous glands are reduced in number and activity but perspiration is normal which contributes to the patient's comfort in the summer months. If the patient has a choice of residence, a warm climate is desirable.

ONE of the localized manifestations of this disorder is evident in the palms. The skin is thicker and drier than normal and deeply marked with criss cross lines. Fissures which are often painful and disabling may develop. The hands should be soaked in clear tepid water for twenty minutes at night and a good emollient cream applied. The cream should also be massaged into the hands after every washing. Two other localized forms of ichthyosis commonly found are (1) thickening of the epidermis on the elbows and knees and (2) keratosis pilaris, which is a horny plugging of the hair follicles. The latter is most commonly found on the extensor surface of the arms and thighs and produces a nutmeg grater-like "feel" on palpation. These two conditions while not incapacitating are often a source of embarrassment because of their cosmetic effect. Temporary relief may be obtained by daily applications of an ointment containing 3 to 6 per cent salicylic acid to the affected areas. Large doses of vitamin A are worthy of a trial (Aquasol "A"® 25,000 units three times a day).

In ichthyosis, much can be done to make the patient comfortable. Greasing is not sufficient to relieve the feeling for it is as important to maintain the water content as the

5. Sulzberger, M. and Baer, R.: Medical Uses of Soap. Philadelphia 1946, Lippincott.

oil content of the skin. This can be done with a good emollient cream which will prevent evaporation of surface water and thus rehydrate the skin. Lowila® emollient (Westwood) and Lubriderm® (Texas Pharmaceutical Co.) are among the many good creams that may be used for this purpose.

Persons with excessively dry skin should not be exposed to sudden changes of temperature.[6] Bed linen and clothing worn next to the skin should never be rough and when washed should be thoroughly rinsed of all soap and bleach. This is especially true in infants and old people and even more so in the bedridden patient where the sheets may be made less irritating by dusting talc between them.

The folds of the body subject to soil and maceration should be sponged daily. A generalized bath should not be taken more than once a week by the person with an excessively dry skin. A shower is preferable because the soap solution can be more completely rinsed off. Since this type of skin will not tolerate ordinary soap, another cleansing agent must be recommended.

Superfatted soaps, such as Basis® (Duke) or Oilatum® (Stieffel) may be accepted by mildly dry skin. The excess fat used in their manufacture is supposed to replace the oil which has been removed in washing. pHisoderm® and Acidolate® are good soap substitutes in liquid form.[7] Since most persons prefer a cleanser in bar form, Lowila cake® is most satisfactory. Chemically it is sodium lauryl sulfoacetate and is non-irritating, only mildly defatting, has a low sensitizing index and its lather has a pH of 5.5 which approximates that of the skin.

If the patient complains of itching, a demulcent bath with oilated Aveeno®, cornstarch or bran is soothing. The skin should be massaged with a good emollient cream daily and also after the bath.

Housewives, surgeons, nurses, bartenders and others who in the course of their work must frequently use soapy water and detergents, may develop rough scaly skin. At this point measures should be taken to prevent the condition from progressing to fissures and finally to vesiculation found in "housewives' eczema." Of course this is not always possible but in many cases, discomfort and disability can be either prevented or reduced if the patient is instructed what precautions to take.

The housewife is in a difficult position, especially when she has young children, but with careful planning she can reduce her exposure to soapy water to a minimum.

The "hand eczema" frequently begins under a ring or in the web of the fingers. This is due to the fact that the hands are not thoroughly rinsed or dried after immersion in soapy water. Sulzberger[5] put it succinctly when he states "soap is poison" to these people.

While doing "wet work," the housewife should wear no rings and should protect her hands with a pair of soft cotton gloves. These will absorb moisture and prevent maceration. Over the cotton gloves she should wear a pair of loose fitting rubber gloves. *Rubber gloves should never be worn next to the skin* where they may cause maceration and aggravate any existing dermatitis.

Children should be bathed with the soap substitute that the mother uses for her own bathing. After washing she should rinse and dry her hands thoroughly and then apply a buffered emollient cream. Acid mantle cream® (Dome) and Polysorb Hydrate® (Fougera) are satisfactory for this purpose. This routine must be followed every time the hands are washed.

Seborrhea, or excessively oily skin, is found mainly on the face and scalp. It is believed due to androgenic stimulation of these glands and consequently not evident before the age of puberty. The skin often has a greasy appearance and cheesy plugs may easily be expressed from enlarged pores. This type of skin predisposes to acne vulgaris, a disorder not to be regarded lightly. It occurs at a time in life when social and emotional adjustments are extremely im-

6. Sulzberger, M. and Wolf, R.: Dermatology. Chicago 1952. Year Book Publishers, page 496.

7. Nelson, L. and Strosser, A.: Annals of Allergy, 2:572 (1953).

portant and if neglected may cause scars not only on the face but on the personality. It is essential to treat the adolescent as soon as the skin becomes oily and blackheads appear.

Treatment of the scalp in these cases is of utmost importance because it will be difficult to suppress the seborrhea in other areas as long as the scalp acts as a focus for infectious bacteria or a collector of grease and dirt.

To combat seborrhea effectively, a preparation must be used which will reduce oiliness, remove the horny plugs blocking the pores and have a bactericidal effect to lessen or prevent secondary infection. Fostex cream® (Westwood) containing sulphur, salicylic acid and hexachlorophene in a lathering base is excellent for this purpose.[8] It is used as a shampoo once or twice weekly depending on the severity of the case. Selsun suspension® (Abbott) containing selenium sulfide is also a shampoo which gives good results in the scalp that is scaly but not too oily. It apparently causes increased oiliness of the scalp when used too frequently.

THE comedone, the initial lesion of acne vulgaris, is formed by the plugging of the pilo-sebaceous orifice with sebum and horny cells. This type of skin must be kept dry and slightly chapped to get rid of the existing blackheads and prevent formation of new ones. The patient should be instructed to wash his face three or four times daily with a mild soap and warm water. The lather should be gently massaged into the face for at least five minutes with the finger tips and then thoroughly rinsed first with warm and then with cold water. After drying, the prescribed medication is applied. When there are many blackheads, lava soap which has an abrasive action is recommended. If the skin is very oily, the face should be sponged between washings with a drying astringent lotion, such as Seba-nil® (Texas Pharmaceutical Co.) or Dermastringe® (Lamond).

When the young adolescent has many blackheads but very few papules or pustules, a 3 to 5 per cent alcoholic solution of salicylic acid will produce a mild peeling and help clear the face. When there are papules and pustules, sulphur is the medication of choice. A satisfactory preparation is a solution made with the contents of a Pronac Packet® (Fougera) and tap water. It is well to begin with one packet of powder to one tablespoonful of water. It is applied at night and washed off in the morning. This solution is a modified Lotio alba but has the advantage of always being freshly prepared and easily varied in strength. This is important since some skins are more sensitive than others and need a weaker concentration and as the skin becomes less dry the strength of the lotion can be increased. Girls may be given 5 per cent sulphur in a cosmetic base similar in color to their skin. This is good for daytime use and makes the acne lesions less conspicuous. When the lotion becomes less drying, resorcin may be added. There are a number of excellent proprietary preparations with sulphur, and with sulphur and resorcin combined, both in cosmetic bases and in lotions that do not leave a deposit. A patient with acne can never be cured by giving him a prescription, no matter how good, and dismissing him. The skin soon tolerates the medication and it is no longer efficacious.

THERE is a difference of opinion about manually expressing blackheads. I think it should be impressed upon the patient that he is to leave his hands off his face. The medication will take care of the comedones. Vitamin A is helpful in many cases, especially in those with a predominance of comedones.

In both acne vulgaris and seborrhea, all existing defects such as endocrine disturbance, focal infections, secondary anemia and any gastrointestinal disorder should be corrected. Proper hygiene, frequent soap and water bathing, sufficient sleep, and a well balanced diet with a few restrictions should be prescribed. Unless the boy or girl is overweight, the diet should not be too limited. A diary, recording all the food normally eaten over a period of two weeks not only reveals the patient's eat-

8. Finnerty, E. F.: New England Journal of Medicine, 255:614 (Sept. 27) 1956.

ing habits but also whether the diet is well balanced.

The diet is discussed and necessary suggestions made. Chocolate, iodized salt, rich and greasy foods are completely eliminated; cream and butter fat are restricted. The patient should be asked to report at intervals so that the strength of the lotion can be adjusted or another preparation prescribed. At the same time the patient will be given encouragement and kept under observation. He and his parents should be told that it is difficult to clear the face entirely during adolescence but with patience and cooperation he will eventually have a clear complexion unmarred by ugly scars.

SUMMARY

THE excessively dry and the abnormally oily skin have been discussed, especially with regard to the alleviation and prevention of those dermatoses to which these types of skin are predisposed.

It is the responsibility of the family physician to recognize these conditions and advise the appropriate care to avoid physical disability and social embarrassment.

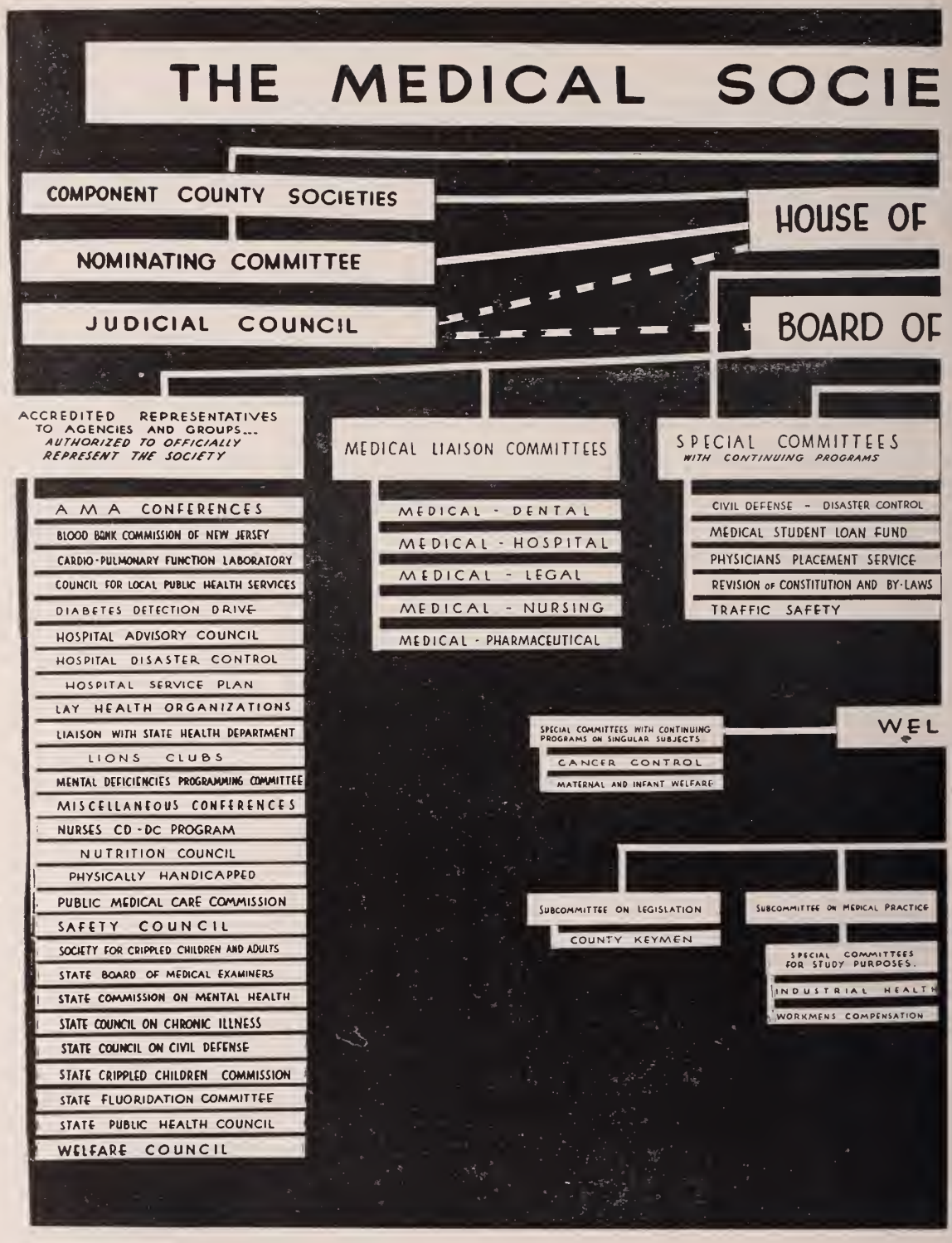
365 Osborne Terrace

Hospitals Lose Liability Immunity

The New Jersey Supreme Court in May 1958 determined that nonprofit and charitable hospitals were vulnerable to damage suits in spite of long precedent to the contrary. By a vote of 5 to 2, the immunity doctrine stemming from the common law in England and based upon a 1925 court decision in New Jersey was overturned. Actually, there were decisions, all alike, in three cases: Collopy *vs.* Newark Eye and Ear Infirmary, Benton *vs.* Westfield YMCA and Dalton *vs.* St. Luke's Church of Hohokus (Mrs. Dalton said she had slipped on the wet floor of the church when she went to Mass on a rainy day in May, 1956, and had sued for $50,000).

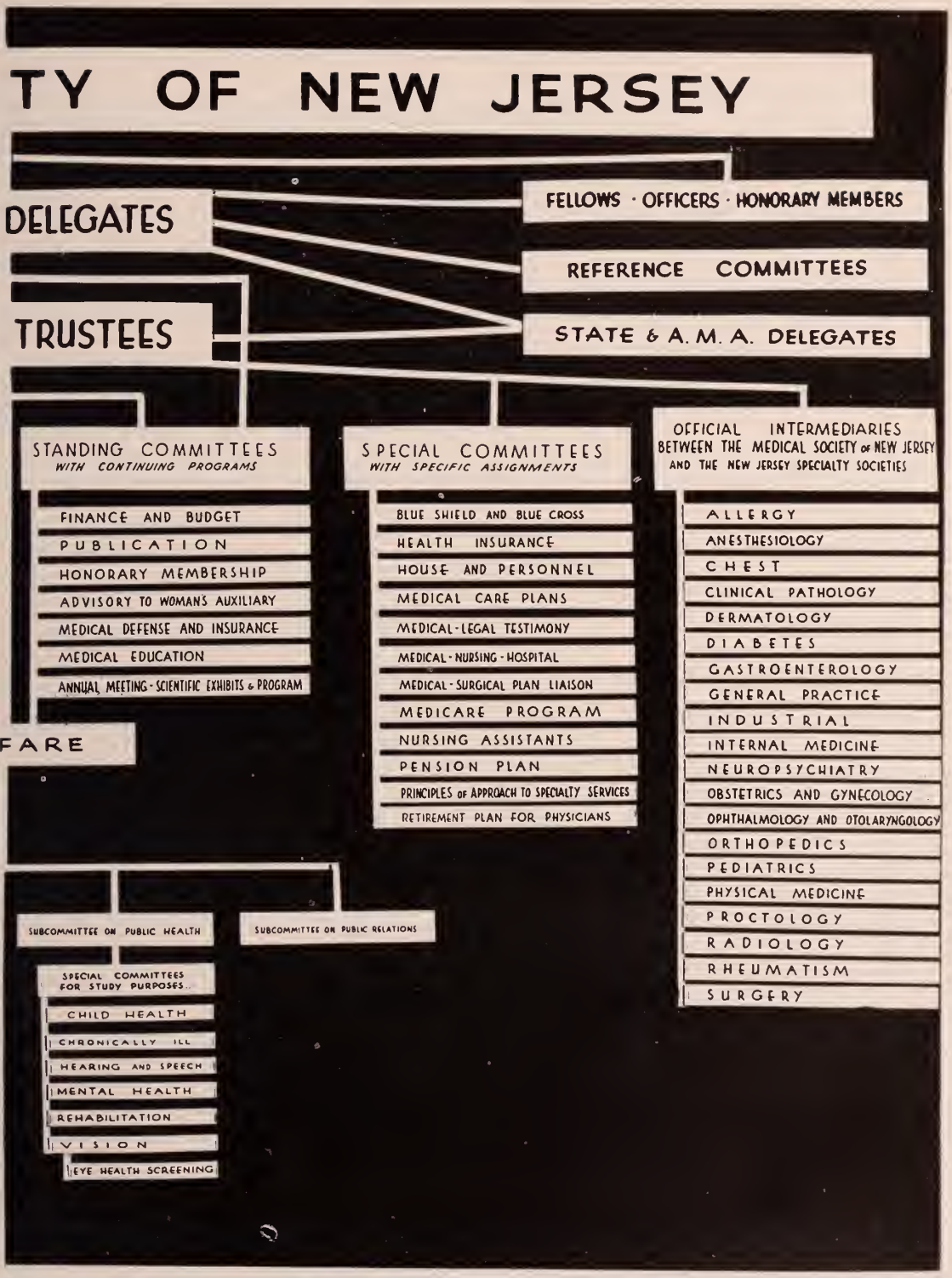
Justice Jacobs said that while the 1925 decision "accurately represented the then prevailing notions of public policy time and circumstances have changed and we do not believe that it faithfully represents current notions of rightness and fairness." He wrote that "Due care is to be expected of all, and when an organization's negligent conduct injures another there should, in all justice and equity, be a basis for recovery without regard to whether the defendant is a private charity." The immunity doctrine, he added, "operates harshly and disregards modern concepts of justice and fair dealing."

In his dissent, Justice Heher said the doctrine dated back to common law before 1839, that the decision of the majority was violating the constitution's separation of powers by upsetting the precedents and that English common law prevails in New Jersey by a provision of the state constitution. He asked, "Would it not be the more prudent course, for the salvation of our constitutional system, the preserving of 'the balance of the constitution' to adhere to the traditional judicial function and leave this essentially legislative question of policy to the popular assembly, the elected representatives of the people?"



ORGANIZATION STRUCTURE

Prepared and presented by Kenneth E. Gardner, M.D., President and Mrs. Edith L. Madden, Administrative Secretary



The above chart gives a bird's-eye view of the structure of your Medical Society. This is further detailed in the pages which follow.

THE MEDICAL SOCIETY OF NEW JERSEY

ORGANIZATION STRUCTURE

Founded July 23, 1766.

Delegated authority to confer the M.D. degree, 1825.

Original constituent of the American Medical Association, 1847.

Chartered by the State of New Jersey, 1864.

Composed of twenty-one (21) component societies divided into five (5) districts as follows:

First District: Essex, Morris, Warren, and Union Counties

Second District: Bergen, Hudson, Passaic, and Sussex Counties

Third District: Hunterdon, Mercer, Middlesex, and Somerset Counties

Fourth District: Burlington, Camden, Monmouth, and Ocean Counties

Fifth District: Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties.

COMMITTEES

1. Committee chairmen are not authorized to make public statements; only the President is the official spokesman for The Medical Society of New Jersey.

2. Resolutions and proposals for projects and programs are received from many sources. However, only the House of Delegates or the Board of Trustees can authorize initiation of a project or program to be undertaken by a committee of this Society.

3. Any member or committee may recommend a project or program, by presenting an outline to the President for consideration by the Board of Trustees. Accepted projects and programs will be referred by the Board of Trustees to the proper committees.

4. Insofar as possible the membership of all committees is composed of representatives from the five (5) Judicial districts in proportionate number to the total membership of the component societies in these districts.

PURPOSES

1. To federate and organize the medical profession of New Jersey;

2. To unite with similar organizations of other states to compose the American Medical Association;

3. To advance the art and science of medicine, elevate professional standards, safeguard the interests of, and promote friendly relations among, members of the medical profession;

4. To promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey; and in general,

5. To render the members of this Society most capable of serving mankind.

COMPOSITION

The Society is composed of Fellows, Officers, Delegates, members, associate members of component societies in good standing, and Emeritus Members. Honorary Members may be elected, but are not members of the corporate body.

ETHICS

"Principles of Medical Ethics" adopted by the A.M.A. govern the conduct of members in all categories of The Medical Society of New Jersey in their relations to each other and to the public.

ELIGIBILITY

No one is admitted to membership in any component society unless he has received the degree of doctor of medicine which this Society deems proper to recognize.

The Society has power to prescribe the duties of its officers and members, fix their compensation, assess an annuity upon the district or county societies in the ratio of their membership respectively, and adopt such regulations as may be deemed necessary, and to hold any estate, real and personal.

The fiscal year of the Society starts on the first day of June.

COMPONENT MEDICAL SOCIETIES

On the first day of January in each year there is levied on each component society a *per capita* assessment to be paid to the Treasurer of this Society not later than five days before the first day of March, together with a list of members for whom such payment is made.

Each component society is the judge of the qualifications of its own members, subject to the right of approval of this Society. It is recommended that every reputable and legally registered physician be deemed eligible to membership in a component society.

Applications for membership are processed through the biographical department of the A.M.A. for such information as may be on file relative to the applicant's record.

Any physician living on or near a county line may hold his membership in the component society most convenient for him to attend, on permission from the component society in whose jurisdiction he resides; *provided that* no physician may be a member of two component societies at the same time, nor of this Society and another state society.

Delegates are elected by and from the component societies. They are members of this Society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their component society, and further subject to their respective component society's continuing in good standing in this Society. Term: three years.

Each component society elects alternate delegates in number equal to the number of regular delegates. An alternate, when serving, has the rights and privileges of a regular delegate.

The number of delegates is based on the number of active members recorded in the Office of the Secretary on December 31st of each year. These delegates serve during the next succeeding year. Each component society is entitled to at least three delegates.

Members of component societies in good standing are members of this Society and are entitled to full privileges.

Every member for whom the assessment is paid is listed as a subscriber to and entitled to receive THE JOURNAL (*Membership News Letter* and *Directory*). If a member has not paid his dues by June 1st, his name is dropped from the rolls.

No assessment is levied against any member in good standing if (a) he attained the age of 70 years, or (b) he is serving with the armed forces of the United States, or (c) he is exempted by the component society from the payment of annual dues for financial reasons, such exemption to be reviewed annually by The Medical Society of New Jersey, or (d) he is a member emeritus.

Associate Members: Each component society, as a requisite of eligibility to active membership may require applicants to serve a probationary period of not longer than two (2) years in the society as associate members. Associate members have such privileges in component societies as the Constitution and Bylaws of the societies may provide, but never the right to vote and hold office. Their dues are fixed by their component society, plus the subscription cost of THE JOURNAL. Associate members of component societies are associate members of this Society but they may not vote or hold office.

Emeritus Members are physicians who have been members in good standing of a component society for at least twenty years, and who by reason of age or infirmity have retired from the active practice of medicine; or members who have been disabled by reason of military service. Nominations are submitted by the component societies, and emeritus membership is conferred by a majority vote of the House of Delegates. Emeritus members have all the privileges of membership except the right to vote and hold office, and their component societies are not assessed for such members provided they are carried as emeritus members in the rolls of the component societies. Emeritus members are not included in the membership of a component society when computing the number of delegates to which such society is entitled.

Courtesy Members of component societies are those who are ineligible for election to active membership.

FELLOWS, OFFICERS AND HONORARY MEMBERS

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society.

All Fellows are members of the House of Delegates.

The Officers are a President, a President-Elect, a First Vice-President, a Second Vice-President, a Secretary, a Treasurer, the elected members of the Board of Trustees, and the Judicial Councilors.

All these Officers are members of the House of Delegates.

Officers are elected by ballot at the second session of the House of Delegates at the annual meeting. No member is eligible for more than one office at the same time, except the President, the President-Elect, the First and the Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next annual meeting.

Officers, except the Judicial Councilors and the elected members of the Board of Trustees, hold office for one year, or until their successors are elected and installed.

Honorary Members are physicians who have attained distinction within the medical profession; or persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Nominations are submitted by recognized medical groups to the Committee on Honorary Membership; the committee's action is transmitted to the Board of Trustees. Nominations approved by the Board are then relayed to the component societies, and the approval of a majority of the component societies is required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds vote of the House at the first session. Honorary Members are not members of the corporate body. At no time may the number of living Honorary Members exceed twenty-five.

HOUSE OF DELEGATES

The House of Delegates is the legislative body of this Society, and consists of the Fellows, Officers, and Delegates.

The President has power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker must be a member of this Society, and his sole duty is to preside at the sessions of the House of Delegates. He does not appoint committees.

The House of Delegates meets on the first day of the Annual Meeting and may meet in advance of or after adjournment of the Annual Meeting. Unless otherwise ordered by the House of Delegates all its meetings are in closed session. Closed session includes officers, delegates, registered members, and guests invited by the Chair.

A quorum consists of at least 10 per cent of the membership of the House of Delegates representing at least ten per cent of the delegation of each of seven (7) component societies.

The House of Delegates has power to:

Prescribe the duties of its officers and its members, fix their compensation, if any;

Assess from time to time an annuity on the component societies in the ratio of their membership;

Adopt such rules and regulations for the Society and the component societies as may be necessary;

Issue charters to county societies applying for affiliation with this Society;

Revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws, upon the recommendation of the Judicial Council.

NOMINATING COMMITTEE

Each component society elects one of its delegates to serve as a member of the Nominating Committee, and one of its elected delegates as the alternate. The immediate Past-President of this Society is the member of the committee representing the Fellows and he is the chairman. He may vote only in case of a tie.

The committee meets in the evening of the first day of the Annual Meeting and reports the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled. The report of the Nominating Committee and election is the principal business of the second session of the House of Delegates.

Nominations from the floor may be submitted by members of the House of Delegates.

The President-Elect advances to the office of President without process of nomination and election.

REFERENCE COMMITTEES

Prior to or immediately after the organization of the House of Delegates at each Annual Meeting the President appoints from the members of the House, reference committees of five members each (unless otherwise provided) to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measures or propositions which have been presented to the House. When a matter is referred to any such committee, it meets, discusses the question referred, and hears debate thereon by any

member of this Society. The roster of reference committees includes:

(a) Credentials—one member to serve with the Secretary and the Treasurer, who are members *ex-officio.*
(b) Resolutions and Memorials.
(c) Constitution and Bylaws.
(d) Miscellaneous Business.
and any others to be created by the House of Delegates as need arises.

On the order of the President or House of Delegates any reference committee may be created a *special* committee to continue after the Annual Meeting, work which has been initiated but which cannot be completed during that meeting; but there is strict limitation, in the order for its continuance, as to its function and term.

BOARD OF TRUSTEES

The elected members of the Board of Trustees are Officers. They are all members of the House of Delegates.

The Board of Trustees is the executive body. It is composed of the immediate Past-President, President, President-Elect, two Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years.

A vacancy in office occurring between Annual Meetings may be filled by the Board of Trustees until the next Annual Meeting.

The Board of Trustees passes upon all recommendations for expenditures in excess of budgetary appropriations.

The Board of Trustees elects its own Chairman and its Secretary.

The Chairman names the personnel of all committees of the Board of Trustees.

Meetings are called by the Chairman, but any four Trustees may—in writing and for stated reason—require the Chairman to call a meeting.

Nine Trustees shall constitute a quorum.

Powers: The Board exercises general supervision over the affairs of this Society, has authority to act between Annual Meetings, and also:

Makes recommendations to the House of Delegates;
Assigns business to and advises in the deliberations of committees;
Supervises the work of the Publication Committee, appoints the editor and such other assistants as the publication of THE JOURNAL may require;
Makes suitable provision for the efficient conduct of the business of this Society;
Engages counsel as necessary and negotiates fees for services to be rendered;
Determines all salaries;
Passes on all recommendations for expenditures in excess of budgetary appropriations;
Bonds the Treasurer, the chairman of the Finance and Budget Committee, and other necessary personnel;
Fills vacancies in all offices and elected committees until the next annual meeting, unless otherwise provided in the Constitution and Bylaws.
Has sole authority to lease, sell, or otherwise convey or dispose of any or all property of this Society, both personal and real.

Three Trustees serve on the *Finance and Budget Committee,* in accordance with Chapter IX of the Bylaws.

State Board of Medical Examiners: Acting for this Society, and in accordance with the statutes of New Jersey, as vacancies occur in the State Board of Medical Examiners, the Board of Trustees nominates for each appointment three members of this Society. The names of such nominees are then transmitted to the Governor of New Jersey.

Executive Committee: The President, President-Elect, First and Second Vice-Presidents, and chairman of the Board of Trustees compose the Executive Committee. It acts on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken is subject to formal action of the Board of Trustees at its next meeting.

Sections: The House of Delegates or the Board of Trustees may provide for division of the scientific work of this Society into appropriate sections whenever necessary.

Special committees may be created by the House of Delegates or by the Board of Trustees. They are appointed by the President or chairman of the Board of Trustees and their functions and tenure are defined in the resolution creating the committee.

JUDICIAL COUNCIL

The Judicial Councilors collectively comprise the Judicial Council, which is the judicial body of this Society. These Councilors are Officers of this Society, and members of the House of Delegates.

There are five councilor districts within the state with one elected Judicial Councilor

from among the membership of each of the five districts. Term: three years. The Councilors elect their own chairman. Duties of the Council are:

1. To sit as an appellate tribunal and to hear and determine appeals properly brought before it from any County Judicial Committee;
2. To interpret and rule on questions of an ethical nature that shall confront the House of Delegates or any other board or committee of this Society;
3. To adjudicate disputes or controversies arising within The Medical Society of New Jersey;
4. To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate County Judicial Committee;
5. To receive, consider and rule on any matter of discipline concerning any member or members of this Society brought to it on appeal from a County Judicial Committee;
6. To make and promulgate from time to time such regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various County Judicial Committees with reference both to the substance and procedure of hearings had by the Judicial Council and such County Judicial Committees. Upon receipt of such regulations by the County Judicial Committees, the members of those committees are bound thereby.

STATE DELEGATES AND REPRESENTATIVES

1. *Delegates and Alternate Delegates to the American Medical Association.* These are elected by the House of Delegates. Their term begins on January 1st of the year following their election. The term of office is for two years, ending on the second December 31 thereafter.

In the absence of any Delegates, any Alternate Delegate is eligible to serve.

Number of Delegates and Alternate Delegates is based on one (1) Delegate and one (1) Alternate Delegate for each 1,000 members of the American Medical Association or fraction thereof as of December 31st of the year preceding the meeting at which the Delegates and Alternates will serve. On December 31, 1957, the number of members of the A.M.A. from New Jersey was 5,484, which entitles The Medical Society of New Jersey to six (6) Delegates and six (6) Alternate Delegates to the 1958 annual meeting of the A.M.A.

2. *Delegates and Alternate Delegates to other medical organizations* are elected by the House of Delegates for one year.

Presently, one Delegate and one Alternate Delegate are elected to attend the annual meetings of the Medical Society of the State of New York and the Connecticut State Medical Society. These medical societies send Delegates to the Annual Meetings of The Medical Society of New Jersey. This Society does not officially reciprocate delegations with any other state medical associations at this time.

When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such Delegates and Alternate Delegates are elected for terms of one year.

3. *Official representatives* from this Society to other organizations, are appointed by the Board of Trustees or by the President with the approval of the Board of Trustees. Their functions and terms do not exceed those set forth in their notice of appointment.

4. *Accredited representatives* to agencies and groups are appointed by the President and/or the Board of Trustees as the need arises.

These representatives may not commit this Society in any way unless so instructed by the Board of Trustees. Such commitment will be an adopted policy of the Board.

MEDICAL LIAISON COMMITTEES

A Liaison Committee is a high level body through which information for subsequent action is brought directly to the respective board of trustees concerning matters of common interest. Such Committees with allied professions were established in 1951 for the purpose of discussing common problems and combining efforts towards common goals.

Medical Society personnel of liaison committees is President, President-Elect, and immediate Past-President, with Executive Officer, *ex-officio*. Many of the other organizations hold to the same pattern. If the membership from the other organization is larger, the Society's personnel is increased from among the presidential officers to an equal number.

SPECIAL COMMITTEES WITH CONTINUING PROGRAMS

Special Committees may be *created* by the House of Delegates or the Board of Trustees. They are *appointed* by the President or the Board of Trustees.

1. *Physicians Placement Service.* This committee consists of 5 members. It was orig-

inally established in January 1952, on recommendation of the A.M.A. that such services be established in each state. The function of the committee is to develop a physicians placement service and to operate in close cooperation with county medical societies.

2. *Medical Student Loan Fund.* This is a 3-member committee established by the House of Delegates in 1957 to administer a fund to be made available to medical students who have satisfactorily completed the first two years of study and who are bona fide residents of New Jersey.

The Albert Barker Kump Memorial Grant is included within the framework of the Medical Student Loan Fund. A goal of $5,000 has been set for this Grant.

3. *Civil Defense-Disaster Control.* This 8-member committee was established in June 1953 by the House of Delegates to initiate a program for the guidance of all component county societies in medical civil defense.

4. *Traffic Safety.* This committee consists of 5 members. It was created in September 1957, in accordance with a resolution of the A.M.A. House of Delegates, which suggested Traffic Safety Committees on state and local levels for the purpose of assisting local government agencies in their programs for traffic safety. This committee has discussed:

1. The importance of emphasizing the moral aspect of reckless driving.
2. The possibility of adopting dependable "constants" for determining physical unfitness to drive.
3. Prohibition of the sale, except on prescription, of medications which diminish physical alertness or efficiency, or alter the mental state of the driver.
4. The desirability of a campaign to induce physicians sternly to warn patients using certain medications not to drive.
5. The importance of encouraging the establishment of trauma teams in all hospitals.
6. The publication in THE JOURNAL of The Medical Society of New Jersey, under the auspices of the special committee, of educational articles.
7. The preparation of educational materials to be made available through physicians' offices to patients.
8. The possibility of recommending physical reexamination of all drivers at regular intervals.
9. Possible support of a campaign against improper and unnecessary use of dark glasses.

Traffic safety is everybody's problem, and physicians can help much in dealing with it. The committee expects shortly to present some suggestions by means of which the sad toll of human life as a result of automobile accidents may be reduced. In the meantime, physicians are urged to caution people about the use of drugs which create changes in mental attitudes; to emphasize the fact that alcohol and gasoline cannot mix; to advise the driver, who in the physician's opinion, is a hazard to himself and others, not to drive; and to practice and encourage courtesy on the road.

5. *Revision of Constitution and Bylaws.* This committee consists of seven members, with President and Executive Officer, *ex-officio;* Legal Counsel and Editor of THE JOURNAL as Advisors.

Present assignment is revision of the last half of the current Bylaws of The Medical Society of New Jersey for consideration of representatives of county societies next spring, and later, submission of the proposed revision to the 1959 House of Delegates. The committee is also studying proposed amendments, and will report to the House of Delegates thereon. The committee's mission also includes the revision of the Constitution and/or the Bylaws as directed by the House of Delegates or the Board of Trustees.

STANDING COMMITTEES

1. *Finance and Budget:* This consists of three members, elected by and from the Board of Trustees and three elected by and from the House of Delegates. Term is six years; Treasurer, *Ex-officio* member-advisor and without vote except in the case of a tie. The committee elects its own chairman. This committee prepares a budget to be submitted to the House of Delegates at the Annual Meeting and controls the expenditure of money by officers and committees. The committee is authorized to require from any officer or committee any necessary fiscal information.

2. *Publication:* This is a 3-member committee elected by the House of Delegates, with the Secretary an additional member *ex-officio,* and the Editor of THE JOURNAL sitting in an advisory capacity. The chairman of the committee is appointed by the President. It is this body which publishes and distributes THE JOURNAL. Reports, papers, and discussions may be submitted to this committee for publication in THE JOURNAL. The committee is authorized to curtail or abstract or to return to the author, such material as seems to it unsuitable for publication.

3. *The Committee on Honorary Membership* consists of three Fellows. It inquires into the standing and qualifications of all nominees for honorary membership in this Society. The committee's action is transmitted to the Board of Trustees by December 1st.

4. *The Advisory Committee to Woman's Auxiliary* consists of five members. It maintains continuous cognizance of the activities of the Woman's Auxiliary and is the official liaison body between the Auxiliary and the Medical Society. It is an advisory body in answering questions submitted to it by the Auxiliary. It is responsible for explaining the policy and programs of the Medical Society in matters pertaining to the Auxiliary. This committee receives and considers suggestions from the Auxiliary for activities in which the Auxiliary might assist the Medical Society. It makes frequent reports on the Auxiliary's activities to the Trustees, and an annual report to the House of Delegates. It ascertains the need for funds by the Auxiliary and has supervision over the expenditure of such funds appropriated by this Society.

This committee recognizes the close relationship between the activities of the Auxiliary in matters pertaining to the policy and programs of the Medical Society and the activities of the committee of the Medical Society having jurisdiction over such activities. Therefore, any program of the Auxiliary in this connection is sponsored by that committee of the Medical Society whose duty it is to deal with that particular activity, and after approval by the Board of Trustees, is financed within the limitations of the budget allotted to that committee.

5. *Medical Defense and Insurance*: This 7-member committee has charge of all matters pertaining to alleged malpractice of members and all other types of insurance, such as health, accident, life, and automobile, which may be recommended to the members. The committee has responsibility for the protection of the members and contracts and relations with the insurance company. It is, at all times cognizant of the financial responsibility of the insurance companies, brokers, and agents with whom it is dealing. It makes frequent reports to the Board of Trustees and annually to the House of Delegates on these matters. It enters into no contracts without the approval of the Board of Trustees or the House of Delegates. It maintains contact with the Judicial Council and refers complaints of an ethical nature to that body.

6. *Medical Education*: This 5-member body provides a continuous program of graduate education for the members within the resources of this Society. It advises upon, correlates and promotes all of the graduate activities of the special committees in cooperation with educational institutions. Currently, its approved projects include:

1. Medical educational programs should continue to be organized and presented at county medical society or local hospital level.

2. Hospitals and county medical societies should feel free to consult with and to avail themselves of the cooperation of the Medical Education Committee.

3. Every responsible group within The Medical Society of New Jersey should keep in mind that the Medical Education Committee is prepared to collaborate in arranging any worthy educational program properly presented.

4. A library of information on medical films, kinescopes, and audio-digest titles should be maintained by the committee at the Executive Offices of the Society in Trenton in order to facilitate procurement of audio-visual aids by medical groups within The Medical Society of New Jersey.

7. *Committee on Annual Meeting* consists of five members. It has charge of all arrangements, plans and programs for the Annual Meeting and all details pertaining to it. It provides accommodations for the annual meeting; for the general and section sessions, House of Delegates, Trustees, committees, Woman's Auxiliary, and exhibits. Its general plans for the Annual Meeting are subject to the approval of the Board of Trustees.

The committee has two subcommittees — Scientific Program and Scientific Exhibits. The chairman of each is a member of the committee. The latter subcommittee prepares and arranges for all details in connection with the scientific exhibit of the Annual Meeting. The Scientific Program Subcommittee arranges for papers, addresses and orations for the annual meeting. The classification and number of scientific sections is determined by the subcommittee.

The chairman and secretary of each *scientific section* are elected by the members of the section. They are responsible to the chairman of the subcommittee on scientific program.

8. *The Welfare Committee* consists of no more than 60 members, exclusive of consultants.

Each component society is represented by at least one member, and candidates for such appointment may be suggested to the President by each component society. The Welfare Committee has supervision over legislative matters, public health, public relations, and medical practice, subject to direction from or approval by the Board of Trustees or the House of Delegates. To the Welfare Committee are referred all questions of professional welfare not included in the specific work of the Judicial Council. The work of this committee is divided into four subcommittees:

Legislation
Medical Practice
Public Health
Public Relations

The chairman of each subcommittee is appointed by the Chairman of the Welfare Committee, with the approval of the President.

Special committees to the subcommittee are formed with the approval of the Board of Trustees, and the members are appointed by the President.

OFFICIAL INTERMEDIARIES

The secretary of each specialty society is appointed by the President as the official intermediary between the Society and the specialty society. The intermediary assists the Society's committees, as far as they require such assistance, in dealing with matters proper to their function and of common interest to the Society.

Requests originating in a specialty society for the official cooperation or assistance to the Society should be addressed to the President or the Chairman of the Board of Trustees. Such requests should not be made to the chairman of a committee. A committee may not adopt or initiate a new project or endeavor until authorization has been granted by the Board.

AD HOC COMMITTEES

From time to time special committees are appointed by the President with the approval of the Trustees—or appointed by the Board—for special purposes. These *ad hoc* committees report to the Board. When its mission is accomplished, the committee is abolished.

SINGLE AREA COMMITTEES

Two special committees with continuing program are subordinate to the Welfare Committee. These "single area" committees are (1) Cancer Control and (2) Maternal and Infant Welfare.

1. *Cancer Control Committee.* The mission of this body, with the approval of the Welfare Committee and the Board of Trustees, is to study and evaluate programs in the field of cancer control, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey. It is independent of the New Jersey Division of the American Cancer Society. The committee tries to avoid duplicating the work of the American Cancer Society. It aims to set up a program of broad scale education to bring the members of the medical profession in New Jersey up to date on recent advances in the diagnosis and treatment of cancer.

The committee uses the resolution of the A.M.A. on a state-wide basis for collection and evaluation of scientific and clinical evidence on claims for the diagnosis and treatment of cancer.

2. *Maternal and Infant Welfare.* This body functions with the approval of the Welfare Committee and the Board of Trustees, to study and evaluate programs in the field of maternal and infant welfare, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey. Its continuing projects include: (1) Review and classification of infant deaths; and (2) Review and classification of maternal deaths.

SUBCOMMITTEES TO THE WELFARE COMMITTEE

1. *Legislation.* This subcommittee evaluates legislation—at state and national levels—proper to the interest of The Medical Society of New Jersey. Its recommendations are subject to the approval of the Welfare Committee and of the Board of Trustees before they can be adopted as the official positions of the Society. Other assignments in the field of legislative concern, such as the preparation of desirable legislation, may be given to the subcommittee at the discretion of the House of Delegates or the Board of Trustees.

The committee may, if necessary, call upon the President, President-Elect, Chairman of the Board, and the Executive Officer for emergency decisions. Its current agenda include these referred items for study and report:

1. Doctors of Osteopathy (Resolution from 1957 House of Delegates)
2. Intravenous Medications by Nurses (Referral from Board of Trustees)
3. Legislation for the control of Blood Banks and blood bank practice in New Jersey (Referral from Board of Trustees)
4. Business Income Tax (Referral from Board of Trustees)
5. Legislation concerning Physical Examination of School Children (Resolution from 1958 House of Delegates)

2. *Medical Practice.* This subcommittee, with the approval of the Welfare Committee and the Board of Trustees, exercises responsibility for the evaluation of matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey; passes upon the projects and recommendations of the special committees to the subcommittee; makes formal recommendations in the field of medical practice relative to official policies and positions of the Society. Its continuing projects include:

1. Study of fee schedules
2. Study of Disability and the Social Security Law
3. Physician's Fee for Completing Accident Reports (Referral from Board of Trustees)

The special committees to the subcommittee are: Industrial Health and Workmen's Compensation.

3. *Public Health.* This subcommittee functions with the approval of the Welfare Committee and the Board of Trustees to evaluate matters of interest to the Society in the field of public health; to pass upon the projects and recommendations of the special committees to the subcommittee, and to make formal recommendations in the field of public health relative to official policies and positions of the Society.

The special committees to the Subcommittee on Public Health are: Special Committees on Child Health, Chronically Ill, Conservation of Hearing and Speech, Conservation of Vision, Mental Health, and Rehabilitation.

4. *Public Relations.* This subcommittee, with the approval of the Welfare Committee and the Board of Trustees, assumes responsibility for evaluating and suggesting programs and projects calculated to further the public relations of the Society as regards the relation of doctor-and-doctor and doctor-and-patient, and the relations of medicine as an organized unit with the general public. Its current continuing projects include:

1. Publication and distribution of the *Junior Health Hints* series to schools, *Health Hints* to the press, *Membership News Letter* and *Periodic News Letter* to cooperating agencies.
2. Preparation and publication of special news releases and publicity materials as required from time to time in furtherance of the Society's business and interests.
3. Preparation for publication and distribution of a membership guide booklet.
4. Continuance of a consultative service in support of the public relations activities of component societies.
5. Completion of the format and achievement of the adoption of a New Jersey Medical-Press Guide to Cooperation.
6. Encouragement of indoctrination programs under the sponsorship of component societies.
7. Responsibility for the bestowal of the annual Golden Merit Awards.
8. Maintenance of a press clipping service for the Society's public relations features, releases, and press notices.
9. Preparation and presentation of suggestions for more efficient management of meetings of county societies.
10. Encouragement of the use of family and/or individual health records.
11. Tetanus toxoid booster shots (Referred by Board of Trustees)

STUDY COMMITTEES

For study purposes there are two special committees to the *Subcommittee on Medical Practice.* They are committees on (a) Workmen's Compensation and (b) Industrial Health.

1. *Workmen's Compensation.* This committee functions with the approval of the subcommittee, the Welfare Committee, and the Board of Trustees, to evaluate matters affecting the interests of the profession and the general public in the field of workmen's compensation and disability benefits under the laws of New Jersey, and to make formal recommendations in this field relative to official policies and positions of the Society.

Referred items for study and report include:

1. Railroad Retirement Board request concerning fees for medical services.
2. Workmen's Compensation forms.
3. Disputed bills in workmen's compensation cases.
4. Workmen's compensation fees in cases of state employees.

2. *Industrial Health.* This body functions with the approval of the subcommittee, the Welfare Committee, and the Board of Trustees to study and evaluate matters relevant to the improvements and maintenance of high standards of health in industry and of the practice of industrial medicine, and to make formal recommendations in this field relative to official policies and positions of the Society.

For study purposes, there are six special committees to the *Subcommittee on Public Health*: (1) Child Health; (2) Chronically Ill; (3) Hearing and Speech; (4) Mental Health; (5) Rehabilitation; (6) Conservation of Vision.

1. *Child Health.* This committee's function, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, is to evaluate matters relevant to the health of all children in their adolescent years, and to make formal recommendations in this field relative to official policies and positions of the Society. Its current agenda includes study of a program for school health examinations.

2. *Committee on Chronically Ill.* The function of this committee, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, is to evaluate matters concerned with the care of the chronically ill, and to make recommendations in this field relative to official policies and positions of the Society.

3. *Conservation of Hearing and Speech.* This committee's mission, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, is to evaluate matters concerned with the conservation of hearing and speech, and to make formal recommendations in this field relative to official policies and positions of the Society. Its current project is to investigate the possibility and desirability of encouraging the establishment in New Jersey of a center for the training of audiologists and speech pathologists, with programs leading to a doctoral degree.

4. *Mental Health.* This committee's aim, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, is to study and evaluate matters relevant to mental health, and to make formal recommendations in this field relative to official policies and positions of the Society.

4. *Rehabilitation.* This committee's assignment, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, is to evaluate means of effective rehabilitation for the diseased and incapacitated, and to make formal recommendations in this field relative to official policies and positions of the Society. Its current projects are:

1. Education of physicians as to the significance of rehabilitation.

2. Investigation and survey of facilities available in all communities as to source of patients and treatment facilities.

6. *Conservation of Vision.* This committee's mission is, with the approval of the Subcommittee on Public Health, the Welfare Committee, and the Board of Trustees, to evaluate matters concerned with the conservation of vision, and to make formal recommendations in this field relative to official policies and positions of the Society. Its current projects include:

(1) Eye Health Screening Program, September 1958.

(2) Methods and eye standards used in the examinations for automobile drivers.

Your Role in Disability Determination

Some $80,000 will be spent by the end of the year for medical examinations and consultations to confirm diagnoses and measure the extent of disability of applicants for benefits under the Social Security Act. These examinations, authorized by medical consultants of the Disability Determinations Service of New Jersey Rehabilitation Commission, cover a wide range of specialties.

Patients who ask for benefits under the disability provisions of the Social Security Act must furnish proof of disablement at their own expense. However, examinations and consultations are obtained at the expense of the government when it is necessary to provide additional medical information to confirm the diagnoses or to evaluate the severity of the applicant's condition.

The Disability Determinations Service processes 1,000 cases per month. Experience gained thus far indicates that about 40 per cent of the cases processed need consultative examinations. The average cost of such examinations is $20.

This report is the first of a series to review the role of the medical profession in the Old-Age and Survivors Insurance program as administered by the state agency. Subsequent items will deal with: (1) Why consultations are necessary, (2) Who are the consultants, (3) How medical reports are evaluated by the agency's medical review team, and (4) Evaluation of applicants for vocational rehabilitation services.

Since the medical profession plays a significant part in this program, it will be helpful to all patients if the medical information is complete, comprehensive, and submitted at the earliest reasonable date.

Social Security and the Physician*

The Special Session was convened at 8:35 p.m., Dr. C. Byron Blaisdell, Moderator.

Dr. Gardner: Ladies and Gentlemen, I'd like to welcome you here this evening, for one of our most controversial issues confronting the medical profession is Social Security for the physician. We are fortunate tonight to have the most able speakers to present to you the various aspects of this issue.

It is my pleasure to present to you Dr. C. Byron Blaisdell, a member of our Board of Trustees and Chairman of our Legislative Committee, who will introduce to you our speakers and act as Moderator. Thank you very much.

The Moderator: President Gardner, Honored Guests, Ladies and Gentlemen: Last evening many of us in this room were startled to read that on Friday, May 16th Congress passed a national health bill covering all citizens. It was, of course, untrue, but it fixed our attention on the possibility. We were then told to shake off our apathy because in Canada in 1959, with the possible exception of the Province of Quebec, private medical coverage insurance plans would, for all practical purposes, cease to exist. Government takes over.

Tonight we consider "Social Security and the Physician." This title is not new. We have heard it advanced that we, as doctors, should be covered by Social Security like so many millions. Those millions are just as nice as we are. We have been told that we are missing a big opportunity. We are told that we are to be given some consideration because of our expressed desire not to be included and that we do not know for how long.

We as a profession have and do presently reject some extensions of Social Security officially and our inclusion thereunder, especially through our parent American Medical Association. But we hear rumblings that all is not well; that many doctors are discontented, many are very uncertain. Three of our forty-eight states have changed their minds.

Is this Social Security for doctors a bargain or is it a dole or is it a taxation without proportionate participation? Are the young being denied their rights by the reactionary thinking of the old? Or should it be alluring only to the old physicians and alarming to the young? We are most uncertain.

Aside from what inclusion under Social Security might do to or for us, we feel also a little more than creepy before the shadows of strain to our national economy and loss of our freedoms. We also have our ears ringing with doubts that we are inadequately informed and that we don't understand all of the implications. If it is good for lawyers—and they are astute fellows, as we know—why not good for doctors?

To help us get our bearings anew, we have with us tonight a Congressman who scarcely needs an introduction to this audience. He is dedicated as a public servant by tradition, education and performance. He is known in Washington as a top authority on Social Security. In New Jersey he is the Republican candidate for Senator—this is a position not new for his family—and he now represents the Twelfth Congressional District. At what must be a great personal sacrifice he has left the terrific press of problems and issues in Washington to help us tonight with his expressed thinking. We may plead that because of our anxiety about the overall potentialities of Social Security we are not asking this sacrifice in any selfish sense.

Ladies and Gentlemen, it is with deep pleasure that I present to you the Honorable Robert W. Kean.

(The audience arose and applauded.)

Hon. Robert W. Kean: I want to emphasize at the start that I am strongly opposed to socialized medicine or anything which in my opinion is a step in that direction. We must keep constant guard against any legislation no matter how sugar-coated toward that end.

I have been asked to talk tonight about Social Security. I will not argue or tell you what you should advocate but merely explain the facts as I see them.

The Social Security system has been in existence now for twenty years. It is no longer an experimental innovation; it has become an integral part of our economy. My strong interest stems back to 1946 when, during my early days on the Ways and Means Committee, comprehensive hearings were held on the subject. My study convinced me of the worth of the program. Since then I have tried to

*This is a report of the symposium held on May 20, 1958 during the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

guide improvements in that direction which would maintain its value to the beneficiaries but would at the same time maintain sound principles and a sound financial structure. There is, of course, political dynamite in the program. The voting and vested benefits have a strong political appeal especially in an election year, and the fight to keep this system sound both financially and socially will be unending.

Now, let's look at the Old Age and Survivors' Insurance System as it exists today. It is a tremendous program. Nine out of ten people who work for a living can look forward to retirement benefits. Furthermore, nine out of ten mothers and children are assured of monthly benefits in case of the death of the family breadwinner. At the beginning of 1958 over 76,000,000 people were insured under the law and approximately 37,000,000 were permanently insured; that is, they will ultimately receive benefits even if they do no more work. In March, benefits were being paid to 11,500,000 people. In the calendar year 1957 13,000,000 people received benefits in the amount of $7,500,000,000. The Fund received more than $6,500,000 from Social Security taxes last year and $561,000,000 in interest from the investments in the Trust Fund. In January 1958 benefits were paid to 351,000 people in our own New Jersey.

By 1975, only 17 years from now, there will be more than 20,000,000 Americans 65 or over and some 16,500,000 people will then be receiving monthly Social Security benefits. The Trust Fund now consists of twenty-two billion dollars invested in Government bonds. You can see how vast is this program and you can also see how even minor changes in the law can have a profound and far-reaching effect on American lives.

To millions of our people the system represents the foundation for their own retirement security as well as the survivorship protection of their dependents.

Our contributory Social Security system is founded on certain basic principles. I believe they are sound. What are these basic principles?

First, benefits are paid as a matter of right without a needs test. Workers and their employees have paid the tax and the former are entitled to benefits whatever their financial situation may be.

Second, the program is financed by the contributions, both from employer and employee, on a percentage of payroll. This insures that management, organized labor and the general public will take a responsible interest in the program.

Third, benefits are related to wages. The principle is in accord with our American system of free enterprise and incentive. The worker who earns more, gets more.

Fourth, the system is not one which should provide for a comfortable retirement. It is—and should be only a floor upon which other types of savings should be built by the individual worker.

Fifth, benefits are paid only to those who are virtually retired. The system is one by which benefits are paid upon retirement. It is a retirement system, not a system to pay annuity at any certain age.

Sixth, this program should be maintained on as sound a financial basis as is possible in any program where there are so many unknown quantities such as how many aged people there will be fifty years from now; what will be the wage scale; what will be the value of the dollar then, and so forth.

There have been many attacks on the financial setup. Some have said that the program does not carry out sound insurance principles because if the system were to be abolished today there is not nearly enough money in the trust fund to pay benefits to all those who have contributed. However, the conception of actuarial soundness as it applies to our Old Age and Survivors' Insurance system naturally differs considerably from a concept of actuarial soundness as it is applicable to private insurance companies. The most important difference is that a social insurance system can be assumed to be perpetual in nature, with a continuous flow of new entrants as a result of its compulsory provisions. Accordingly, it may be said that the Old Age and Survivors' Insurance program is actuarially sound if it is in actuarial balance by reason of the fact that future income from contributions and interest earnings on the accumulated trust fund will over the long run support the disbursements for benefits and administrative expenditures.

It has also been argued that the trust fund is a phony, that the Government is spending money for current expenditures which it is receiving from the Social Security tax. Another common charge against the present system is that the taxpayer will have to pay twice for Social Security, once when he pays his Social Security contribution and again when he pays his general taxes to redeem the Government bonds now held by the Social Security fund. This charge has been repeatedly

made but it is a false charge. The reason for the misunderstanding is that, while the taxpayer has to pay twice, he doesn't pay twice for his Social Security. He pays twice because he pays for two separate things.

It has been said that the government spends the money in the Social Security trust fund for its current expenses. The government spends the proceeds of its bond sales (including those which it has sold to the trust fund) because the Congress has authorized certain sums to be spent. No money can be spent unless the Congress authorizes it. This money would be spent anyway, whether or not such a trust fund was in existence. If the Treasury did not sell its bonds to the trust fund it would have to raise the money in some other way, either by selling bonds to the individuals, banks or insurance companies; or Congress would have to raise additional taxes to find the money it had instructed the Executive Department to spend.

Bonds sold to the trust fund are as much a part of the national debt as are any other obligations of the government. It is true that when these bonds mature all taxpayers will have to contribute in taxes to paying them off. But the fact that these sums were invested in the trust fund does not add one nickel to the amount which the taxpayers will have to pay anyway in redeeming these bonds when due. So it can't be asserted that those contributing to Social Security are, to any extent, paying for their insurance twice over. The test as to whether this is an honest trust fund is this: when the money is needed by the Social Security system, can it call upon the trust fund for the money without in any way increasing the government debt? It can. If you or I put some money aside as a reserve for some contingency and when this contingency arises we are able to spend this money without increasing our debts, we certainly would have had a real reserve; and this is the case with the Social Security trust fund.

Now, in the past there has been considerable difference of opinion as to whether self-employed doctors of medicine should be covered under the system. It was primarily because of this difference of opinion that 125,000 physicians were *not* brought under Social Security by the amendments in 1956 which extended coverage to more than 200,000 self-employed professional people including dentists, lawyers and veterinarians.

An argument frequently used by those opposing physicians' participation in Old Age and Survivors' Insurance is that many physicians never retire and therefore would not receive Old Age Insurance benefits which are payable to qualified retired workers at age 65 and at age 62 for women if they wish to take a discount and get it ahead of time.

Now, there is no quarrel with the argument that doctors are hard working people and wish to continue to work long after the minimum retirement age. Like other people, however, doctors do feel the effect of the aging process and some have to retire before they had intended and, like other people, some become ill and have to stop work prematurely. In addition, some physicians die when relatively young and before they have been able to build up any security for their dependents. Their widows and minor children should welcome the protection afforded by the Old Age and Survivors' Insurance.

What can Social Security mean to the self-employed physician and his family? If the self-employed physicians are given coverage, one who has an average net income of $4200 a year or more and who has a wife and two children would have protection for them, if he died, in the amount of $200 a month, tax free, until the older child reached the age of 18. At that time the monthly benefit would drop to $162.80 a month until the younger child also reached the age of 18. After that there would be no benefits until the widow reached the age of 62, and if she waited until 65 her benefits would be resumed at the rate of $81.40 a month unless she re-married.

If the children were age 6 and 4, these payments would amount to $32,000, assuming that the mother and children lived until the younger child reaches the age of 18. The widow, if she lives to the age of 62, would then have a life expectancy of 17 more years and here benefits, in addition to the above-mentioned $32,000, would be in excess of $15,000. The Social Security system also provides a lump sum payment of $255 to help cover funeral expenses.

An income of $81.40 a month is equivalent to $976 a year. It would take $32,000 of accumulated capital invested in government bonds at three per cent to produce an annual income of this amount. And if there is a permanently and totally disabled child who was disabled before he reached the age of 18, benefits will be payable to this child and to his mother regardless of the age of either. Furthermore, if a doctor should retire at the age of 65 and had earned an average of $4200 a year, he would receive monthly tax-free income of $108.50, which would be increased to $162.80 when his wife also reached the

age of 65. At the age of 72, benefits would be paid to him as an outright annuity.

In addition, the law provides for a waiver of premium for a person who becomes totally disabled before the age of 65. Because of this protection, a disabled individual can qualify for full benefits at 65 even though full contributions have not been made.

Let us consider also the disability protection which would be available to physicians. If in 1965 a physician should become the victim of a very severe, long term disability he would be eligible for cash disability benefits beginning at the age 50. The disability benefits based on earnings of $4200 would amount to $108.50 a month up to age 65 as long as he remained disabled.

For all this protection the self-employed doctor with a net income of $4200 or more a year would pay premiums of $141.75 annually. This premium would rise by a series of steps beginning in 1960, rising every five years until in 1975 there would be a premium of $267.75 annually.

Now, while many physicians have already received Social Security credit and for a period have been protected under the program, generally this protection has been very limited. Among the physicians who have Social Security credits are those who served in the Armed Forces, physicians employed in medical departments of business and industry, those employed on hospital staffs, laboratories and clinics which are operated for profit, and many of those who are also employed by educational institutions and other non-profit groups. Under the present law, however, self-employed physicians have little opportunity to participate in the program on a continuing basis and to maintain an insured status.

With the present high income tax rate it is difficult for any individual to set aside substantial savings for his dependents. This is particularly true of those with moderate income. The young physician starting his private practice usually has high expenses and heavy family obligations at a time when his income is relatively low. Death of the young physician at this time is a real hardship on his widow and children. Social Security payments might be the one thing which could keep his family together.

Enactment of legislation along the lines of the Jenkins-Keogh Bill would not be an adequate substitute for the coverage of self-employed physicians under Social Security. These bills, which permit a tax deferment on moneys voluntarily paid into special trust funds, are not entirely satisfactory for meeting the problem of economic insecurity. The individuals most likely to participate are those who are relatively well off financially and who can expect to receive a substantial reduction in income tax through their contributions into the special fund. Individuals who are not so well off are not likely to be able to participate fully in this voluntary plan because they will need to use their income to meet current expenses.

Old Age and Survivors' Insurance and such a plan as the Jenkins-Keogh Bill should be considered as complementary rather than competitive so that coverage by Old Age and Survivors' Insurance would not interfere with the personal savings program.

It is difficult to have a comprehensive and fair Social Security system with some individuals covered and some individuals not covered. I believe that most self-employed physicians, if they are fully informed, would generally favor coverage. However, knowing the deep respect that Congress holds for physicians, I realize that persuading our legislative body to include you will continue to be difficult unless most representative groups of doctors favor inclusion. Thank you.

THE MODERATOR: I think that is a very forthright expression. We certainly appreciate your talking to us the way you did because what we want is advice and you have certainly given it. Now we have listened attentively to our distinguished speaker who has certainly told us what he knows and believes about our subject. When occasion demands, we can be adequately vocal on our own here in The Medical Society of New Jersey, but on an occasion like this, in recognition of the stature and importance of our principal speaker who, as you all know, is one of the senior and most respected members of the most important House Ways and Means Committee, we have turned to Chicago and to AMA for help. The Medical Society of New Jersey wants to know the facts, not only the pros and the cons but where there are areas of agreement which can be reached and recognized and then possibly expanded. Our next speaker is acclaimed by Dr. Allman and all who worked with him as being a smart man and a straight thinker. He speaks with authority, since he is AMA's top legal counsel. We have been fortunate enough to have plucked him from his planned orbital engagements and have him here in Atlantic City. I am happy to introduce to you, who may not already know him, Mr. C. Joseph Stetler.

MR. C. JOSEPH STETLER: Dr. Allman just

handed me a note. He said he denies ever saying that I was smart. (Laughter)

Dr. Blaisdell, Congressman Kean, Dr. Allman, Mr. Dunaway, Ladies and Gentlemen: It's a privilege and a pleasure for me to be invited to New Jersey to talk to you about the position of organized medicine on this question of compulsory coverage of doctors under the Social Security system and to discuss the reasons for that position as I understand it.

In my comments concerning the current significant and the potential problems related to the Social Security program you might detect in my remarks some slight agreement with the position of the medical profession, but in the event I fail to make that point clear later on in my remarks, may I say at the outset that I personally concur wholeheartedly in the present position of organized medicine in opposition to compulsory coverage. Of course, in so doing, unfortunately I find myself in equal disagreement with some of the remarks that Congressman Kean has just made to you.

I wish I could stand up here tonight and pose as an expert on Social Security, because it is a broad, involved subject. But with thirteen titles in the Social Security Act itself and with some twenty-odd national and state programs that fall into that general category, I'm going to have to limit my remarks and I'll talk exclusively, as the Congressman did, about compulsory coverage under Title 2 of the Act.

Organized medicine, through its House of Delegates of the American Medical Association and its Board of Trustees, has stated its positive, active opposition to compulsory coverage of doctors under Title 2 of the Social Security Act; has indicated no objection or opposition to voluntary coverage under the plan. I should like to say that the possibilities of the Congress legislating to include physicians under the program on an *optional* basis is so remote that it really deserves very little consideration or comment.

This position of organized medicine was established in 1949 by the AMA House of Delegates and it has been reiterated every year since that time. As a matter of fact, it wasn't until June of last year, in New York, that I heard any comment presented before the Reference Committees of the House of Delegates in favor of bringing doctors under the Social Security system.

After the December 1955 meeting of our House of Delegates, which was held in Boston, most of the state medical societies returned home and conducted a poll of their membership. New Jersey was no exception. Just about two years ago this time, in May of 1956, a poll was conducted here and of the doctors that responded—and that was about 57 per cent of your membership—the majority reiterated their opposition to compulsory coverage.

Although uniform questionnaires were not used around the country, 36 of the 40 states that polled their membership found still a majority of the doctors in opposition to being included under the program.

Recognizing in advance a difference of opinion on this subject, and in your State as well as around the country, I think we can still say that the predominant opinion among doctors is still one of opposition to being brought under the program on the basis that they must be brought in: and that's on a compulsory basis.

Now, let's consider the reasons for this position. The reasons can be presented in two categories. One would be labeled as philosophical and the other has sometimes been referred to as the practical reason.

As individual citizens we are all aware of the increased importance which the federal government is assuming in our daily lives. As individuals, we have been somewhat content complacently to accept the philosophy of big government and have permitted it to take root and to flourish in our country. We tend to accept willingly or unthinkingly promises by the federal government of increased security in exchange for individual freedom and responsibility. But the preservation of freedom is a continuing job of those of us who have inherited it. It is time that we joined forces to fight unsolicited or unnecessary paternalism on the part of the federal government whenever and wherever we find it. It is time we stopped apologizing. We should commend organized medicine on the position which it has taken in various fields, and one particularly in connection with Social Security. Organized medicine should be commended for their refusal to succumb to the trends of the times and for their refusal to let the federal government solve all of the personal and professional problems that confront them.

Yesterday Dr. Allman put it this way: Any government that is big enough to give you everything you want is big enough to take away everything you have.

Individual doctors and organized medicine have for the past several years led the fight against federal encroachment in their personal and professional affairs. As the prime

target for many federal social planners, the medical profession more than any other group has been sensitive to and keenly aware of the additional attempts at intervention and control.

Doctors have observed, have seen and have been seriously concerned with the inevitable pattern and growth of social security schemes in foreign countries. They have been concerned about the growth of these programs from lump sum benefits to retirement benefits, to survivorship benefits, to permanent and total cash disability benefits, to temporary cash sickness benefits, and finally to national compulsory health insurance.

The Social Security Act in this country was born of the depression in 1935 and despite twenty years of continuing prosperity we have seen the same pattern of growth in this country. We have started out with lump sum benefits; we graduated to retirement benefits, to survivorship benefits; last year, through the passage of HR 7225, to permanent and total disability benefits. We've got two steps yet to go. We have seen in the twenty years since 1935 when the program was adopted, this program move father and farther away from the original concept of a base or a floor of protection for the aged and have seen it move closer and closer to a concept of cradle-to-the-grave for all possible problems, economic or otherwise, that are involved in just the process of living.

Now, while it's possible for a number of reasons that have nothing to do with medicine that major health programs were not enacted or additional federal appropriations passed during the 85th Congress, this doesn't mean that the people that have a different philosophy from you are not active in this field. This is evidenced by the fact that there have been more bills introduced in the 85th Congress, which still has a couple of months to go—more bills introduced in the 85th Congress than in any Congress in the history of the United States.

I was in Seattle at a meeting of the Washington State Medical Society a year ago. I was participating on a program with Dr. Ludwig of Los Angeles and he told a story which is worth repeating because it illustrates this point very well. Dr. Ludwig was talking about the enormous number of bills that had been introduced in the 84th Congress and what he foresaw for the 85th Congress, and he likened it to the story of the cab driver in Washington, D. C., who had the lady sightseer as a passenger. They had driven in front of the National Archives Building. Over the arch of that building are inscribed the words: "What is Past is Prologue." The woman asked: "Driver, what do those words mean?" He thought for a while and finally said, "Lady, that means you ain't seen nothin' yet."

When Dr. Ludwig told it, it sounded just like another good story; but unfortunately it seems that he made an accurate prediction. As I say, in the 85th Congress there have been more bills introduced than in any other Congress in our history. That totals over 600 medical bills, bills of primary medical implications. And of this 600, over 75 proposed some liberalizing amendment to what I believe is an already too liberal Social Security Act.

These bills fall in various categories. They would provide for compulsory coverage of doctors under the Social Security program. They would increase benefits. They'd increase taxes; they'd lower the age of 50 anywhere from 40 or to any age at all for entitlement to cash permanent and total disability benefits. They'd provide for temporary cash sickness benefits.

Most important, however, there are some bills in that group that would provide for the federal subsidization of hospitalization and medical care for the OASI beneficiaries. This is the Foran Bill that Congressman Kean alluded to and it's the one we have talked about and which you talked about: HR-9467. It is going to involve some strange logic on the part of the medical profession to oppose any type of amendment to the Social Security Act and in the same breath ask Congress to bring them, on a compulsory basis, into a program which has traditionally been the vehicle for the socialization of the medical profession.

In discussions of this subject you have heard discussion on whether Social Security is an insurance program, whether it is actuarially sound. Is there really a trust fund?

Social Security is not insurance. To refer to it as insurance is a misnomer. In 1937, when the United States Attorney-General was arguing the constitutionality of the Social Security Act before the Supreme Court, he commented on that in very clear and concise language when he said: "Social Security benefits are gratuities to be paid by the federal government to individuals. The act, however, creates no contractual obligation with respect to the payment of benefits."

This fact was again admitted in 1954 in a report on the Social Security program published by the House Ways and Means Committee. The public should know that employees and self-employed persons have no insurance contract under the Social Security program.

Social Security taxes are compulsory; but there is no obligation on the government to pay benefits. As a matter of fact, it was the division of the taxing powers in the benefit provisions of the act that resulted in the Supreme Court declaring this act to be constitutional.

Is the program actuarially sound? Well, under normal insurance standards and under normal insurance concepts, and that's the one I could understand best, I think the answer to that is emphatically no.

In this 1954 report of the House Ways and Means Committee, which I mentioned, the Committee alluded to the ratio between benefits being paid to beneficiaries under the program and taxes paid into the program and they said in that report that beneficiaries as of December 1952 who were then receiving benefits were receiving $24 in benefits for every fifty cents of combined employer-employee taxes paid into the system. In 1954, through the liberalizing amendments of that year, this ratio was further distorted to $30 in benefits to every fifty cents in taxes paid. The 1956 amendments to the act, which also increased the benefits, distorted this ratio further; however, figures have not been released on what the distortion is as of the present time.

In 1950 Congress amended the Social Security Act and increased benefits by 75 per cent. In 1952 they increased benefits by 15 per cent. In 1954 they increased benefits by 15 per cent. In 1956, which incidentally was another election year, they legislated cash permanent and total disability benefits and brought in other groups under the act. Under this 1956 amendment, 275,000 people qualified for permanent and total disability benefits and 375,000 additional people were brought under the act. When the Social Security Act is liberalized, the liberalizing amendments are not earmarked only for the people who are then the wage earners who are going to pay the taxes on these benefits. They are, rather made retroactive to all the people that are then on the rolls. As an example, the 1954 amendments were made payable to six and a half million current beneficiaries at an annual cost of $450,000,000, none of which, of course, would be paid by the recipients since they were already retired or in a survivorship category—the $450,000,000 annually to be paid by future taxpayers.

You may ask what about the twenty-five billion dollars currently in the trust fund? The fact is that this amount is not one-half enough to pay the ten million persons now drawing benefits under the program. Obviously, it is completely and hopelessly inadequate to pay the benefits which will accrue from the wage credits that have already been credited to the eighty million plus wage earners now in the labor market in this country. This doesn't take into consideration future liberalizations to the Social Security program, which, if the past pattern is followed, seem to be inevitable.

Last year for the first time, I believe, payments out of the trust fund exceeded income into the trust fund. I believe this happened about 20 years ahead of schedule. This deficit cannot be ignored. It is a definite symptom of a sick system. Certainly if our recession continues that we are now in or if it becomes worse, this deficit is bound to increase.

Advocates of Social Security coverage should review the tax experience of other countries who have become engaged in social security schemes. In France the Social Security system presently consumes 35 per cent of payroll. In Britain, which has a less pretentious system than ours, the system is broke and is being subsidized each year by higher and higher taxes.

Now, for a few minutes let's talk about some of what are called the practical reasons for opposition. Congressman Kean alluded to the retirement ages of doctors, and that's a fact. A relatively small proportion of doctors do retire at the age of 65. Some very sound studies that have been made, and *not* by the American Medical Association, indicate that over 85 per cent of doctors between the ages of 65 and 72 are in active private practice. Of those that have retired, 50 per cent have done so after the age of 74.

If these figures are correct, and we have no reason to question them, it would seem that the average doctor will probably not take advantage of the retirement benefits under the program because there is an income limitation. If he earns $1200 or more, he must forfeit his retirement benefits until he reaches the age of 72, when that income limitation is waived.

At this stage I'm also sure that many of you who are in favor of coverage will say: What about the generous survivorship benefits? I have no intention of trying to tell you that you can purchase commercial private insurance benefits as cheaply as you can obtain your benefits through the Social Security system. It's true that if you can ignore, and in many instances you can, the retirement benefits under the program possibly for your Social Security taxes you can buy comparable survivorship benefits. However, I do not consider this as the basic ar-

gument against coverage. To the contrary, if this is your sole approach to the problem, I would say that financially for the moment you are better off under the Social Security system.

Some of you read an article in *Medical Economics,* February 1958, that was labeled "Is Social Security a Good Buy?" The author began by saying that it is as difficult to compare commercial insurance with Social Security as it is to compare apples with oranges; however, this fact didn't deter him from proceeding immediately to some invalid conclusions. He based his conclusions on what he called economic facts.

Now, it is difficult, for me at least, to use the term economic facts and Social Security in the same breath, but it is even more difficult to talk and rationalize on Social Security in an economic vacuum without any reference to the moral, the political or the philosophical aspects of this program.

In your assessment, however, of the practical aspects of this proposition, keep some of these things in mind:

Commercial insurance protection begins immediately upon the filing of an application. Social Security benefits are dependent upon an insured status which takes a minimum of eighteen months.

Commercial insurance is contractually guaranteed. Social Security benefits are not.

Commercial insurance can be tailor made to your individual needs. Social Security formulas that have been set up by the government favor those in the low income group.

Commercial insurance premiums are voluntary. Social Security taxes are mandatory.

Commercial insurance permits the selection of your beneficiaries. The government selects and can change beneficiaries under the Social Security program.

Commercial insurance benefits do not stop on the re-marriage of your widow or your children. Social Security benefits do.

Commercial insurance does not depend on the number and the ages of your children. Social Security benefits do.

Commercial insurance is payable at a fixed age irrespective of income; not so Social Security.

Comparing commercial insurance to Social Security benefits is like comparing a contract to a promise or comparing a mutual agreement to a unilateral, arbitrary action, or comparing private enterprise to socialization.

Is Social Security a good buy? Is it a bargain? If you mean by that are current beneficiaries getting a lot for a little, the answer is yes.

Let me assure you, however, that there is no magic to Social Security. Dollars still come out of pockets, and every dollar that's paid under the Social Security program must eventually be paid by somebody.

The Social Security Act specifically provides the right to amend, alter or repeat any provision of this act is hereby reserved to Congress. This means that just as today's beneficiaries can pressure Congress for more and more benefits, the voters of tomorrow that are going to be asked to foot the astronomical bill of Social Security can pressure Congress for tax relief through reduced benefits.

Some say that will never happen. However, with the continual liberalization part of our future program, I believe it can and will happen and when this situation develops, when it comes it will be your plans for the future, it will be your Social Security benefits that are destroyed.

In conclusion, let me say this: The basis of the decision as to whether doctors should request coverage ultimately returns to these considerations: You either accept a compulsory, inequitable, inadequate government controlled system of legalized relief or you don't. If you decide to accept this program, make sure it's the right decision. If you decide to buy a ticket on this gravy train be sure you are ready to take the whole trip. As I look at the time table, this train has only two more stops: Temporary cash sickness benefits and national compulsory health insurance.

Thank you very much. (Applause)

The Moderator: I don't know what Dave Allman will really admit to having said about Joe Stetler, but you can draw your own conclusions.

One thing that I want to make most emphatically clear tonight is, when Congressman Kean was invited here he came as our honored guest and one in whom we must put our trust. We cannot get away from the fact that there is no other constitutional agent to do for us the things that have to be done except Congress. I sometimes feel rather badly when anyone talks of Congress as a third party or seems to have any sense of opprobrium applied toward Congress because that is our Congress. We have nothing else. It's the caliber and the type of man who goes to Congress and works for what he believes to be the best principles of preserving what we want to have as our type of economy and our way of life. And when we are told that our economy and way of life may be changing by circumstances which we, as doctors, or perhaps other groups may feel are not controllable and

therefore must be met, nevertheless it's up to us to do and resist as best we can, as we try to do tonight, some of the things in which we are quite convinced, and we hope are well grounded, and at the same time realize that our hopes, our fears in all the years rest with having proper representatives in Congress and in the Senate.

We hope that in Congressman Kean's coming here that he has and will still give to us much that is to clear our minds. We also hope that he will carry with him as he goes back to Washington tomorrow a sense of our sincerity to do nothing to show a lack of respect for what we believe is his honored judgment. We just hope that he will go back and think with us along some of the lines that we would like him to think and we hope that he will correct many things in which we may be wrong if our insight and our judgment is presently in error.

While Dr. Allman, Congressman Kean and Mr. Stetler are sorting these questions into categories so we won't have needless repetition, we have, through the efforts of Mr. Ardell Everett, who was with us last night—and thinking what is the alternative we can come up with to help the young doctor meet his obligations—two gentlemen who have a series of entertaining slides and with a commentary which will show you what they think private industry and enterprise can do. This is merely a matter of trying to stand on your own feet somewhat longer, which we certainly hope we should do for a long time.

We are rather fortunate tonight in getting the benefit of so much legal ability because Mr. Everett was fortunate enough to secure a gentleman who must have a great deal of insight on this, otherwise he wouldn't have this title. The gentleman who is going to talk to us is the chief legal counsel of the National Association of Life Underwriters. I believe that represents nearly seventy or eighty thousand agents and about 170,000—anyway, it's a big operation and so to be there he must have quite a lot of ability.

Without more ado, I'd like to introduce to you Mr. Carlisle M. Dunaway, who will introduce these slides which are a part of private industry's thought about this situation. Mr. Dunaway.

Mr. Carlisle M. Dunaway: Thank you, Dr. Blaisdell.

Just to get the record straight, the National Association of Life Underwriters, of which I'm the General Counsel, represents approximately 75,000 life insurance agents. However, I'm not here tonight to give you a life insurance pitch. I think that Mr. Stetler did about as good as job on that as I could possibly have done.

And one other thing I'd like to say, in presenting this little narrative of ours I sort of feel in the position of the mother whose little boy came home one day and she found him busily writing away at his little desk—he was in the fourth grade—and she said, "Johnny, what are you working so hard on?" And he said, "Well, mother, tomorrow we've got to have a little composition on a family history and I'm working on that." He said, "While you talk about it, tell me one thing, mother," he said, "where did I come from?" And she said, "Well, Johnny, the stork brought you." He said, "Well, what about you, mommy?" She said, "Well, the stork brought me, too." "What about grandma?" "Well, the stork brought her, too." So he went back to writing his little composition.

So the next day he was called on to give it and he got up and started reading it something like this: "For three generations there's not been a natural birth in our family." (Laughter) Well, the point of that story, if any, is that Johnny's mother sort of underestimated his intelligence.

Now, I hope that you won't feel, when you see this little bit that we are doing here, that we are underestimating your intelligence. You will probably see a lot of things and hear a lot of things that you already know. As a matter of fact, you have already heard some of the things I'm going to say from the previous speakers, particularly Mr. Stetler. But keep in mind that while this may seem, shall we say, a little 'corny," it was designed by us principally for a somewhat less sophisticated audience than the doctors.

When we got this little narrative up, we didn't do it with the aim of winning any popularity contests. As a matter of fact, I guess the biggest endorsement we have had of it so far is that it has elicited a three-page, single-spaced letter to me from Secretary Folsom in which he denounced it as being inaccurate and misleading and a public disservice.

Really, the reason we got this up was, while we had heard all these years about Social Security, we knew the people had been sold on the idea, Number One, that almost everybody had it; Number Two, it was a good thing, and that was about all they knew about it. We agreed with all of that. This is not an anti-Social Security film. It's an anti-over-expansion of Social Security slide film. There is a great difference there.

We, too, agree with Social Security and

maybe the doctors don't agree with this, but we think it is a program that will furnish a basic floor of economic protection. There is probably a great need for it in this country, in our very complex industrial civilization. What we are concerned about and what we are trying to get across to the public is that it should not be over-expanded. There shouldn't be these continual election year expansions. We are trying to tell them something about the way in which it is financed, the ultimate cost of it, who is going to pay that cost. And so let me repeat, if there is anything in this little narrative that leads you to believe that we are anti-Social Security as such, well, that is not what we intend at all. But there are some things that we should know and do about it.

If we were to ask Mr. and Mrs. Ed Gregory if they thought Social Security was going along O.K., they'd probably reply why, sure, it seems to be working pretty well for us. Ed is 67 and his wife is 65. Before retiring on January 1, 1957, Ed had been the owner of a prosperous little neighborhood drugstore. As a self-employed person he did not begin paying Social Security taxes until January 1, 1951. During his six years of coverage he paid the maximum amount of these taxes. Even so, by the time he retired he had paid, all told, just a little over $600. If he and his wife lived their expected lifespan they will receive about $27,000 from Social Security. That's better than a forty to one return on Ed's money. And so for Mr. and Mrs. Ed Gregory Social Security does indeed work exceedingly well.

Then there is young Tom Brown's family. Tom was only 29 when he died at the end of 1956, leaving a widow, Mary, and two children, one and two years old. He had been paying Social Security taxes for eight years and his salary was $250 a month. Benefit payments due his family will come to about $33,984 from now until the older child reaches the age of 18; $1594 more until the second child reaches age 18; and then Mary stands to receive some $13,660 in widow's benefits commencing at age 62; making a grand total of $49,238—all of this for the mere $390 in Social Security taxes withheld from Tom's salary by his employer and which was the maximum amount that could have been withheld from his $250 monthly salary. Of course his employer matched Tom's $390 with $390 of his own, making a total of $780. Still, for every one dollar that Tom and his employer paid in taxes, Tom's family stands to receive $63.

Now, let's look at the case of Carl Jackson, a self-employed professional man who first came under Social Security on January 1, 1956. He was then 63½ years old and he became eligible to draw Social Security on July 1, 1957. His wife also became eligible to draw benefits then because she was just over 62 years of age. So when Carl retired on July 1, 1957, after having earned at least $4200 in both 1956 and 1957, his total liability for Social Security taxes had come to only $268. For this small sum, he and his wife will be entitled to monthly benefit checks which stand to total $28,500.

Is it any wonder then that most Americans agree that Social Security is a real bargain? I say most Americans because there is an increasing number of thoughtful people, leaders in the fields of business, medicine, finance and government who have looked beyond the apparent something-for-nothing aspects of our Social Security program. They have discovered some very disturbing not to say dangerous implications that indicate Social Security is not the bargain it presently appears to be.

Most everyone agrees that some form of Social Security is in order. The system does afford a measure of dignity and self-respect to its beneficiaries and an essential sense of security to the aged, the infirm, the widowed and the dependent children. Social Security is intended to provide these citizens with a basic floor of economic protection against want. That this concept is generally accepted is clearly demonstrated, I think, by the fact that both major political parties since 1936 have continuously reaffirmed their support of the system. And rare indeed is the individual candidate for public office who would think of declaring himself against the program.

I repeat then that most everyone agrees that some Social Security is in order. So if it is in order, if it is helping people in these essential areas, what are we talking about? What is it about Social Security that is disturbing more and more people? Well, fundamentally they are bothered by the insidious and entirely false notion most people have that Social Security is cheap, that it gives a lot for a little, that it is a bargain. They know differently. They know that in the long run most people will have to pay a great deal to keep the system going.

Make no mistake, for everyone presently receiving payments, Social Security is a bargain and does give a lot for a little. Consider the fact that through the year 1956 no employee could have paid more than $837 in Social Security taxes. Self-employed people who didn't start paying taxes until 1951 could

not have paid in more than $67. Actually, in a great many cases only small fractions of these amounts were paid.

Yes, people who now get benefit checks are getting a lot for a little. Benefits run as high as $108.50 a month for single people, $162.80 a month for man and wife, and $200 a month for families of three or more. So at the present time, just a few months' benefits are enough to equal the total taxes paid by an employee or self-employed person. The remaining payments, which may run on for years, represent pure profit to the recipients.

Well, then you may ask: Where does all that money come from? You will recall in the first case that I mentioned that Ed Gregory had paid in a little over $600 and that he and his wife stood to receive about $27,000. This leaves a deficit of $26,400. Who makes up the difference?

Tom Brown, who died at the age of 29, paid in $390 and his employer paid in another $390 for a total of $780. Tom's family is eligible to receive some $49,238, leaving a deficit of $48,458. Who makes up this difference?

Finally there was Carl Jackson who came in the program at the age 63½ and paid in $268 for which he and his wife may receive about $28,500; that leaves a deficit of around $28,232. Who makes up the difference?

Now, these are just three examples. The individuals and families receiving these bargains are legion. Where does this additional money come from? Has the Social Security program discovered, at long last, a means of conjuring pennies from Heaven? Hardly. The answer is really quite simple, although it has been obscure all too long by reams of elaborate and confusing statistics.

I feel sure that every person sitting in this room understands all too well that pennies and dollars come out of pockets. Every single dollar paid out by Social Security must be paid in by some one, that's for sure. I think it is understandable then that an increasing number of people are worried about the fact that the government is repeatedly expanding the Social Security program, that we are repeatedly giving more and more money to more and more people.

For example, Congress approved an increase in benefits in 1950, the average increase being only 75 per cent. Again in 1952 benefits were increased by about 15 per cent on the average; again in 1954 by another 15 per cent. And again in 1956, another election year, Congress added to the system a potentially costly program of cash benefits for totally and permanently disabled workers commencing at age 50. Congress also lowered the age at which women can begin to draw benefits, from 65 to 62—more and more money for more and more people. And the 1956 expansions were made despite the dissenting views expressed in Congress by those who were trained to read the financial handwriting on the wall.

Those of us who are going to have to foot the bills should learn now that Social Security is not cheap. The seeming cheapness of the program not only has much to do with its popularity, but it is also the main force behind the demands for more and more Social Security. Many people think that they pay for their own benefits, so it is natural that they don't mind paying higher taxes if they can get in return higher payments in the same proportion. However, this just isn't the way the program works.

Whenever Social Security benefits have been increased, the increases have not been earmarked only for those actively at work, those who will have to pay increased taxes for their increased benefits. In addition, increased payments have gone also to those already drawing Social Security. To these fortunate people benefit increases come as pure gravy.

For example, under the 1954 amendments alone more than six and one-half million beneficiaries received increases at a rate of about $450,000,000 a year at no cost whatever to themselves. This undoubtedly has encouraged many to anticipate future favors.

It is significant that most of these beneficiaries of Social Security are over 21 years of age and eligible to vote. All of which brings me to another of the very real dangers to the soundness of our Social Security system. The liberalization of Social Security benefits is a most appealing political move. Any Congressman can win the favor of a large number of voters by supporting measures to increase Social Security benefits. Conversely, he feels that he could incur serious disfavor by opposing such measures. Undoubtedly the members of Congress are well aware of the fact that Social Security benefits are not something for nothing. Far from it. When a Social Security beneficiary spends a dollar, he is spending a dollar that some taxpayer, directly or indirectly, is doing without. It's just as simple as that. In fact, the taxpayer must put in more than the beneficiary draws out to cover the cost of benefits plus the operating and overhead expenses of the program. So for every dollar paid out in Social Security benefits, a little more than a dollar from Social Security taxes must first be paid in.

But, you may ask, what about the twenty-two and a half billion dollars now in the Social Security trust fund? Isn't this a good, healthy reserve? Isn't it big enough to allow us to cut the melon and have more benefits without increasing Social Security taxes? As a matter of fact—the amount of the trust fund wouldn't be half enough to pay what has already been promised to the more than eleven million people now drawing benefits. It would be hopelessly inadequate to cover the benefits the system will sooner or later have to pay under the present law on account of the Social Security wage credits that our present working population has acquired to date.

All told, the program has incurred an unfunded accrued liability in excess of $300,000,000. To put it another way, if the Social Security program were a true insurance program, which it is not, it would have a deficit of more than $300,000,000. This unfunded liability is increasing year after year and will have to be paid for by future Social Security taxes. Mistakenly, most participants in the Social Security program feel that their respective benefits have been paid for as they went along.

I'm sure that when you think of the Social Security taxes you pay—and excuse me, this is not applicable to you, of course—do you think of them as money set aside for you and held for your future retirement? Well, it just isn't so. Actually, the low rate taxes collected so far have been used in large part to provide the bargains enjoyed by the beneficiaries who, I might add, have paid for less than 10 per cent of their own benefits.

Now, what about the people who are presently paying taxes? Where is the money that they think is being stored away for their future security? It just isn't. It hasn't been collected yet. Social Security is a system that takes from Peter to pay Paul, and the more we expand the benefits to Paul, the more we take from Peter's pocket. To illustrate, let's say that everyone now receiving Social Security checks is Paul. Everyone paying Social Security taxes is Peter. Children not working now are Paul, Juniors. Paul gets his Social Security bargain all right and maybe the present taxpayers think that they are going to get a bargain, too. The hitch is that by the time they are ready to draw benefits, the Paul, Juniors may object to the staggering taxes then needed to keep the system going. If present trends toward liberalizing Social Security continue, by the time Paul, Junior takes on the burden of paying for the program his Social Security taxes may be as high as six or seven per cent or more of his taxable income. In other words, they may be as much as, if not more than, his federal income tax. If he should happen to be self-employed, they would be even more so because Social Security taxes of self-employed people are one and one-half times the taxes paid by employees.

If a Social Security tax of 7 per cent, for example, should exist for employees, the tax rate on self-employed Paul, Junior would be 10½ per cent. If his income were $4200 per year, his Social Security tax would be $441. On the other hand, if he has a wife and two children and files a joint return, his federal income tax would not exceed $276 even at today's high rates. In comparison then I think you will agree that the price tag on his Social Security would be expensive indeed.

If Paul, Junior objected to his Social Security tax load, all of those now drawing benefits might be in bad shape indeed. Paul, Junior might even demand that his Social Security tax be reduced. If this happened, those people now paying for the big bargains currently enjoyed would find themselves getting less than what they had provided for their predecessors. This situation, of course, is entirely different from that of private pension plans or other voluntary retirement programs where advance provision is made for future benefit payments. The voluntary plans and policies do not expect one man to buy another man's benefits.

Most Americans don't realize that the law already provides for a series of four tax increases to take effect between now and 1975. These increases will be matched by similar contributions by employers and it is quite possible that even these tax increases may be insufficient to meet the cost of the present indebtedness, much less provide funds for additional benefits. So you can see that it is going to be expensive and when it becomes too expensive, then the next generation, the Paul, Juniors, can simply call a halt. If we have piled up a tax burden too great for them to bear, they don't have to bear it.

The Social Security Act specifically provides that the right to alter, amend or repeal any provision of this Act is reserved to the Congress. This means that, just as today's beneficiaries can pressure Congress for more and more benefits, the voters of tomorrow (who will really be the ones to foot the bill) can pressure Congress for tax relief in the form of curtailed Social Security benefits—our Social Security benefits. Make no mistake about it, this can be done. This major consideration is entirely aside from the fact that future inflation can cut Paul, Junior's burden and our

present benefits without any change in the dollar amount specified by law.

Employers match the Social Security taxes paid by their employees. This is another part of the something-for-nothing concept that is misleading, to say the least. The Social Security tax paid by an employer is to him just another cost of doing business. Along with other business expenses, it is passed along to the consumer in the form of higher prices unless it is passed to the employees in the form of lower wages.

Then, too, most people do not understand that the program at present is actuarially immature. Here is what I mean by that rather formidable phrase. Today, while nine out of ten active workers pay Social Security taxes only about five out of ten of our older citizens are drawing Social Security benefits. However, about twenty years from now roughly nine out of ten senior citizens will be eligible to draw benefits. In addition, the proportion of old people in our population will have increased considerably by that time. Finally, the average benefit paid to each of these people will be substantially larger than it is today, even assuming that there is no further liberalization of present benefit schedules. These are three very important reasons why government actuaries estimate that even under the present law the Social Security program will be paying out over fifteen and a half billion dollars a year by the year 1975. They are also the main reasons why Social Security taxes will then have to be about double what they are now.

Let's examine now the interest paid by the federal government on the Social Security trust fund. While this interest is a source of revenue for the fund, nevertheless it is the American worker, the taxpayer who actually pays it. We taxpayers pay it; anyway you look at it, we pay every last dollar, in higher prices, lower wages or higher taxes. The American worker must make good every single dollar that is being paid out and promised under the Social Security program. If larger benefit payments are made in the future, the American worker must make them good. There is no way around it.

So we come to the key question: Should we be against Social Security? Well, the answer, in our opinion, is a simple and unequivocal no. No one is being asked to be against Social Security and no one is suggesting that we offer a bare cover to the aged and dependents, surviving families.

What then are we talking about? Well, we think that we need to see the problem clearly, to grasp the full facts. If we are clear as to the problem, we know that Americans will have enough common sense to come up with a practical solution.

Just what is the problem? The problem is to see to it that Social Security is kept in balance; that we do not permit it to degenerate into a mere give-away program; that it does not become a runaway program. In short, we want to prevent Social Security from collapsing like a house of cards.

How can we do that? *First,* we can do it by realistically facing up to the fact that there is no such thing as getting something for nothing. I'm confident that the vast majority of Americans appreciate the importance of proper incentives for work and savings, furthermore they value the right to spend their own money as they choose. Certainly we must not let Social Security become a force that jeopardizes the true economic security of our people and interferes beyond reason with our freedom of choice and spending money. Yet Social Security might do all this if we continually add new and increased benefits.

Second, we must understand that our Social Security program will be safe only if we keep it sound. Social Security will remain sound if we can confine it to the basic benefits now being provided, keeping in mind the original goal of the program, which is to provide only a basic floor on which the individual can build for himself. Let's keep that goal in mind. Let's see that Social Security is kept safe and practical by keeping it within bounds.

To accomplish this, there are certain things each of must do. We need, each of us, to constitute ourselves a one man committee as such. Let's each of us first master the facts about Social Security, particularly its cost. Let's pass these facts along to our friends and acquaintances. Since just about everyone is covered by Social Security today, people usually are glad to listen to their friends who can advise them on the subject. Let's participate actively in community and organizational projects that aim in achieving sound economic housekeeping, stable financial procedures, and a sound currency for our country.

Third, let's make sure that our civic organizations and social and fraternal groups are alerted to the necessity of keeping the Social Security program within reasonable bounds.

Fourth, when the issue of Social Security comes up before Congress, let's urge our Senators and Representatives to insist on safeguards rather than indiscriminate give-away additions that might ultimately cause the program's destruction. Let's make ourselves centers of influence, through letters, meetings and

personal conversations, on the dangers of overexpanded Social Security.

Fifth, let's remember that it is fundamental for our own personal security to place our principal reliance on our personal thrift programs. We should use Social Security only as it was originally intended; namely, as a base on which to build our own programs and not as a substitute for these programs. Let's make it our personal responsibility to ourselves, our children and to our fellow citizens to help safeguard Social Security by keeping it sound. In that way we will all benefit. Any other course can only mean economic suicide.

Thank you very much.

(Applause)

THE MODERATOR: I am sure that we have enjoyed this opportunity to see something that is going to be put and is being put across the country as a means, and I think a fair means, of bringing people's thoughts into focus. Now Dr. Allman and the gentlemen over there have the cards. Dr. Allman, are the gentlemen all ready to answer them?

DR. ALLMAN: Yes, I think so, Mr. Chairman.

THE MODERATE: Would you like to moderate, then, whatever is necessary at this time?

DR. ALLMAN: Congressman, would you take the first card you have, please?

CONGRESSMAN KEAN: The first question I have is this: since doctors are generally rather high income tax contributors, are they not paying heavily for everyone else's Social Security without any benefit to themselves?

The answer is: "Yes." Social Security is considered a cost of doing business by all businesses in this country and the Social Security taxes that they pay are added to the cost of the goods that you buy; therefore, you are paying for other people's Social Security without getting any benefit yourselves.

DR. ALLMAN: Mr. Stetler?

MR. STETLER: "In matters of this nature where urgent decision is not needed is there no way in which the sense of the physicians as individuals may be learned to govern the decisions of the parent organization? Is there no way in which we may be given both sides of controversial questions early in the game?"

Well, of course, giving you both sides of this controversial question is one of the reasons we are here tonight. This may not be early in the game. Your JOURNAL has carried the pros and cons of Social Security coverage. This matter has been discussed and debated around the country. I've participated in some of them. Our House of Delegates has considered it for eight years. I don't think they have turned away anybody who wanted to express a different view. Possibly there are other ways or better ways in which this can be done. The AMA would have no objection of hearing from you, but the American Medical Association is like the United States Congress. Every person individually can't express his views to the Congress or the AMA. You have to do it through your constituted procedures, which is your House of Delegates and through your delegates to the AMA. If they don't properly represent you, then they have to go with an instructed vote.

But I do think that on the basis of polls that have been conducted the majority of doctors still are opposed to compulsory coverage; and as long as that majority feels that way, the position of the medical society nationally must of necessity be one of opposition. There may be other ways and better ways to get both views to you. I don't know what they are.

CONGRESSMAN KEAN: I have a funny one here. "Do you believe in private enterprise?" (Laughter)

Of course, I believe in private enterprise and my belief is that government should not assume anything that private enterprise can do as well. I don't think government should ever interfere in any business and do anything that private enterprise can do.

DR. ALLMAN: Thank you.

Mr. Stetler?

MR. STETLER: This question says: "How do the dentists and lawyers feel about Social Security?"

Well, I would wager that probably most lawyers and most dentists don't feel about Social Security. I suppose that those who do feel anything about Social Security momentarily feel pretty good about it. I think it probably might be a more appropriate question to ask their grandchildren how they feel about Social Security, but, of course, we can't do that.

I don't believe that the attorneys have as much of a stake in the future implications of the Social Security programs as does the medical profession.

DR. ALLMAN: Thank you.

Congressman?

CONGRESSMAN KEAN: "Mr. Stetler has pictured the progress of creeping socialism that points toward socialized medicine. You started your remarks by stating categorically you were opposed to socialized medicine. *Question*: If what Mr. Stetler says is true, and you believed it, would you still say we should be included?"

I don't believe what Mr. Stetler says is true. I don't believe it, so that I do believe that it would be wise for you to decide that you want to be included.

Dr. Allman: Mr. Stetler?

Mr. Stetler: Obviously, if we had agreed, they wouldn't have asked the two of us to come here tonight. (Laughter)

The next question is: "Since Social Security is now the law of the land, why should one small group like the AMA hold out against it? We have had Social Security for twenty years and we are not yet a socialistic state."

Well, Social Security is the law of the land, but the law of the land as written, of course, does not include physicians. Now, this goes back really to that first question. This questioner asks: "Why does the AMA hold out against it?" The AMA still has to represent a majority of the physicians who have expressed themselves through the only constituted means that we have. When the majority of doctors want to be covered by Social Security, the AMA or you will ask for it. However, it would be just as inequitable to have a minority of the physicians of this country commit the entire medical profession to compulsory inclusion under the Social Security system.

The questioner says: "We have had Social Security for twenty years and we are not yet a socialistic state." Well, I know that we are not a socialistic state as he means it, but socialism is not something that's like turning a light on and off.

He has another question on the back: "How do you explain the fact that lawyers and dentists and veterinarians voted to belong to the Social Security system?"

I don't explain it. As an attorney I think my profession made a mistake in voting to go under the Social Security system; however, the majority of the attorneys in this country expressed themselves in the American Bar Association's House of Delegates and voted to go under it. That's why they went under it. I do not think the attorneys have as much of a stake in the future implications of this program as do the physicians.

Dr. Allman: Congressman Kean?

Congressman Kean: "Why couldn't OASI for doctors be selected on a voluntary basis?"

That is the question I get quite a lot. A lot of doctors write me and say they want Social Security on a voluntary basis. I'll tell you why that's impossible. In the first place what would result would be what insurance people call adverse selection. The doctors with a lot of minor children who are young would all want to come in; those who were not in too good health at that age would want to come in; and also a lot of the older doctors who might feel, for some reason or other, that they were going to retire. In other words, the system would lose a tremendous amount of money on account of the voluntary system because those who would be getting their benefits the soonest would be the ones to come in.

In the second place, you could not say to the worker in General Motors or any other worker, the lawyers, for instance: You have to come in under a compulsory system, but we are going to let doctors come in under a non-compulsory system, because they would say: Well, let's change the system and let those of us who want to get out, who happen to be bachelors and will never get any benefits out of it probably anyway, get out of the system. Here is a similar query. "Are there any voluntary groups in the system?"

Yes, there is one and that is clergymen. The Congress felt that the constitutional provisions of separation of church and state would make it impossible or politically impossible to force a clergyman of a church that didn't believe that they should contribute anything like this into the system and therefore clergymen, as individuals, were able to choose up to a certain date—I think we extended it one year last year—whether they shall come in or not; and if they don't choose within that one year, they may never come in.

Mr. Stetler: I think I finally found an area that the Congressman and I agree on, so I better say something about it. I believe on this business of optional coverage, although theoretically it seemed like a very attractive thing and certainly it is something that would be more equitable if the doctors that wanted to go under the Social Security system could and those who wanted to stay out could stay out, I do believe there are some good reasons why this cannot be done and will not be done —reasons that are just not stated.

This question says: "If Social Security benefits are paid on a gratuity basis and not on a contractual basis, what confidence have we in buying government bonds?"

I would only say this: if benefits under the Social Security program get larger and larger and more liberal and if taxes are not increased or if the system is not permitted to mature, only two things can happen: either benefits are going to have to be reduced or else taxes are going to have to be raised drastically.

The question of the purchase of government bonds is not germane to whether Social

Security benefits are paid on a gratuity basis or on a contractual basis.

Dr. Allman: Congressman?

Congressman Kean: One question here: "Are Senators and Representatives covered by Social Security?"

Not in their function as Senators or Representatives, but since most members of Congress also have some private business, they are covered under that private business. For instance, I'm covered under Social Security, in fact about five years ago my business lost money and I was afraid I was going to lose one year of Social Security coverage. I had three minor children at that time and I was so anxious to remain covered that I went out and got an executor's fee, which I wouldn't have gotten that year, to cover me that year from an estate that I was trustee of, so that I could continue my Social Security coverage so that in case I died my wife might get the $200 a month tax free which I wanted her to get. Now the youngest child is eighteen and I don't give much of a hoot about it.

Dr. Allman: Mr. Stetler?

Mr. Stetler: "Do you think that 125,000 people in this large country can turn the tide against future amendments and changes to the Social Security program?"

I don't know whether they can or not. I'd like to hope and think that they could. However, I don't think they are going to have to do it alone. I believe that finally some other groups and even the press and some elements of the public are becoming more aware of the implications of Social Security.

I believe that last year was the first time that I recall reading much in the public press discussing the future implications of Social Security. And what brought that about? I think the one thing that brought it about was the deficit last year in the trust fund in terms of expenditure exceeding income. This one factor seemed to awaken the public to some of the future possibilities of Social Security and to ask some sensible question concerning its actuarial soundness.

I think the fact that the insurance industry has seen fit to prepare these slides indicates that possibly that industry is becoming concerned with Social Security. In the next few years you will find more and more groups that may question whether complete coverage is a desirable thing.

Dr. Allman: Congressman?

Congressman Kean: I'd like to discuss that same question.

I've got a question here: "Is it not true at the present time the government is paying out more than it takes in, according to Folsom?"

Of course, it's not the government; it's the trust fund. That is true. Last year there was a deficit in the trust fund of about three hundred million dollars, and this year the deficit will be about eight hundred million dollars. Now, in 1960 the Social Security tax increases and there will not be a deficit for the next two or three years. The reason for that deficit was a miscalculation by the Social Security actuaries of what women would do.

You remember in 1956 an amendment was passed, which I didn't feel was too wise, which reduced the age for the benefits to women to 62 and they provided that if the women took the money at 62 they would get only 75 per cent of what they would have gotten if they waited until they reached the age of 65. The actuaries estimated that a great many women would not take their money at 62, but would wait until 65 so that they would get the full benefit. But it happpened that the women felt that a bird in the hand was worth two in the bush and so nearly all the women have claimed their benefits at 62. That means that the Social Security fund is paying out more than it expected. There also was an estimate with reference to farmers, who found ways of getting into Social Security pretty easily, which was not expected.

Now, that eight hundred million dollars looks like a tremendous amount of money, and it is an awful lot of money; but based on the long term actuarial needs of the total Social Security system, when you figure out that the benefits estimated—I figured in 1975 was about sixteen and a half billion dollars—you said only fifteen and a half billion dollars—it doesn't matter so much in the long run with reference to the actuarial soundness of the system which has really only been estimated for about fifty years, that the trust fund will continue to grow until about 2010 and then after that you don't know what the situation will be and it will have to be figured all over again. It won't interest any of us much.

The Moderator: I see Mr. Stetler has something to say which may cast further light on this—I'll give you a few seconds—but I do want the Congressman to have the last word.

Mr. Stetler: I think the Congressman in his last answer gave the best argument against the Social Security program. I mean this: It's obvious that the program is in unsafe hands. I don't care whether it's an actuary or anybody else, if he is trying to predict what a woman is going to do, you know he is in trouble. (Laughter)

Congressman Kean: Well, I didn't understand what you said about the first part of that, the best argument against. I don't know about predicting what anybody is going to do and what is going to be the situation in the United States fifty years from now. We certainly hope that it will be a better country, that it will be a country where our children will be able to live fuller lives than we do now, and we hope that it will be a period when we won't have had any wars.

And one thing with reference to that I want to say with tremendous importance, and that is to back up the fight that the President is making and that all of us are making against inflation. If we have inflation, I don't know what is going to happen to the Social Security system because, as has been said, there is only a certain amount of money that has been put in there in taxes; and if the value of the dollar is cut in half, people are going to say: What's $180.50 a month? We want more, and where are we going to get the money? In that case, the trust fund will be of no value at all.

Now, some of the people who were advocating the changes in the Social Security system in 1950 wanted to change this system from a contributory system into the type of system that they have had in most countries abroad and that is that one-third is paid by the employer, one-third is paid by the employee, and one-third is paid out of the general revenue. Now, you know what the general revenue is. That's you. So in those cases you people who pay most of the taxes would be taxed twice.

The thing we must do and the people of the United States must realize is that the Social Security system must be kept sound. Every time there is an increased benefit the people must realize there must be increased taxes. There is talk about bills that have been introduced in Congress. Most of them are completely irresponsible bills. They are bills that have been just put in by a member of Congress to increase benefits. He doesn't know—most of them know very little about the Social Security system and they have been put in there for—well, for vote-getting purposes because the objective of paying more benefits seemed pleasant, but none of them have provided how this is going to be paid for. And as was said in the pictures, for every nickel that Social Security benefits are increased, somebody has to pay for it and that's why I have been working to increase benefits where I could, but above all basically the system must be kept sound.

(Applause)

The Moderator: I would like to ask Mr. Stetler, Mr. Dunaway and Dr. Allman to step down now. I know some of you would like to come forward, say hello to them and ask the question you didn't get answered.

Aside from that, I want to thank you for having been such a wonderful audience, and also thank our speakers for having been such a wonderful group.

This adjourns the meeting.

The Blue Cross Inter-Plan Bank

From South Dakota to Singapore . . . the subscriber to Hospital Service Plan of New Jersey (Blue Cross) finds that his identification card is as good as a wallet of Traveller's checks, should he or any of his enrolled dependents unexpectedly need hospital care while traveling out of the state.

Throughout the United States, such a subscriber is entitled to full service benefits in more than 6,000 hospitals. These are the hospitals with contracts with the more than 80 Blue Cross plans. They cooperate with the Inter-Plan Service Benefit Bank. Interest in the *modus operandi* of the Bank inspired a resolution at the 1958 Annual Meeting of The Medical Society of New Jersey leading to this explanatory article.

The Inter-Plan Bank is a reciprocal program, organized a half dozen years ago under auspices of the Blue Cross Commission of the American Hospital Association to provide service benefits to subscribers of any Blue Cross plan, when treated in a member hospital in any area served by another plan. In brief, the Plan Bank works this way:

Upon the subscriber's admission to a cooperating out-of-state hospital, the Blue Cross plan serving that area (the "host" plan) is notified by the admitting office. Through the speedy facilities of a leased private wire tele-

type system, that plan asks New Jersey Blue Cross for verification of the subscriber's standing.

New Jersey Blue Cross files are immediately checked to determine enrollment status as well as any prior utilization by the patient, and word is promptly teletyped to the host plan to cover the admission to the extent of days available.

The "host" plan covers the subscriber's bill for all the benefits it regularly provides for its own subscribers, except for the number of days' care . . . which is determined by his own plan. In other words, the New Jersey subscriber hospitalized out-of-state is treated temporarily as a member of the Blue Cross plan in the area where hospitalized, and is charged only for any services not provided in the local Blue Cross contract. After discharge of the patient, New Jersey Blue Cross reimburses the host plan through the Inter-Plan Bank.

If treated in a hospital anywhere in the world which is not one of the 6,000 cooperating with the program, the New Jersey Blue Cross subscriber would be reimbursed by the plan at the rate of up to $15 a day toward his hospital bill. If treated as an out-patient at any hospital, the subscriber would be reimbursed by New Jersey Blue Cross up to $15 per day for a maximum of three days' eligible treatment for any one accident or condition.

The Inter-Plan Service Benefit Bank, in the few years of its existence, has rendered splendid service to thousands of Blue Cross subscribers overtaken by accident or illness away from home. As an example of the magnitude of that service . . . last year, New Jersey Blue Cross subscribers were covered for out-of-state hospital benefits to the extent of more than $3,000,000 through the Bank's operations.

Announcements • • •

Psychiatric Research Association

Announcement is made of the annual meeting of the Eastern Psychiatric Research Association at the Brooklyn State Hospital on Clarkson Avenue in Brooklyn, New York.

The meeting starts on Thursday morning, October 23 and concludes Saturday afternoon October 25. The Saturday afternoon session will be held at the Waldorf-Astoria Hotel on Park Avenue and 50th Street, New York City.

A rich program has been developed covering almost every aspect of psychiatry. For further information, write to Dr. Theodore Robie at 676 Park Avenue, East Orange, New Jersey.

Obstetrics and Gynecology Examination

The next examination of the American Board of Obstetrics and Gynecology will be held on Friday afternoon, January 16, 1959. For further details write to Dr. Robert L. Faulkner, 205 Adelbert Road, Cleveland 6, Ohio.

German Ophthalmologist to Speak in New York

Professor G. Meyer-Schwickerath of Bonn, will give a series of lectures on the treatment of fundal pathology: Wednesday, November 19 from 5 to 7 p.m.; Thursday, November 20 from 5 to 7 p.m.; and Friday, November 21 from 10 a.m. to noon. Registration fee is $30. This series will be given at the New York Eye and Ear Infirmary at 218 Second Street, New York. For further information write to the Registrar at the New York address.

Infantile Glaucoma

On Monday evening, December 1, Professor Harold G. Sheie of Philadelphia will discuss the management of infantile glaucoma before the New York Society for Clinical Ophthalmology. This is the annual Schoenberg Memorial Lecture. It will begin at 8:15 p.m. at the New York Academy of Medicine, 2 East 103rd Street, New York.

Symposium on Infectious Diseases

On Wednesday afternoon, November 5, a symposium on infectious diseases will be held at the Jersey City Medical Center. The moderator will be Dr. Carroll M. Leevy, Associate Professor of Clinical Medicine at Seton Hall. The program includes papers on respiratory viruses, the use of steroids, viral meningitis, the control of infections in hospitals, and the abuse of antibiotics.

This meeting is held in conjunction with the Alumni Association meeting. For further details write to Dr. Samuel Cohen, 100 Clifton Place, Jersey City, N. J.

Medical Meeting in the Bahamas

Three medical conferences are announced for Nassau, British West Indies, this winter. The first, which concentrates on internal medicine, runs from November 28 through December 18, 1958. Then comes the surgical conference, December 29, 1958 to January 17, 1959. Finally a general practitioner's seminar is scheduled for the fortnight beginning January 18, 1959. A certificate of participation will be issued to each physician who attends the lectures or seminars. For details, write to Dr. E. L. Frank, 23 East 79 Street, New York 21, N. Y.

Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays reflecting original work on problems related to the thyroid gland. The competing essays may cover either clinical or research investigations, should not exceed 3,000 words and must be in English. Duplicate typewritten copies, double spaced, should be sent to Dr. John S. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1959.

Urology Award

The American Urological Association offers an annual award of $1000 for essays on clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to interns and residents.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held in Atlantic City, April 20-23, 1959.

For particulars write to William P. Didusch, 1120 N. Charles St., Baltimore, Md. Essays must be in his hands before December 1, 1958.

Air Force Offers Residency in General Practice

The Air Force has entered the Age of Space and now needs general practitioners. Approved residencies in General Practice are available at the Maxwell Air Force Base, Alabama and at certain civilian hospitals.

The Air Force physician trained in general practice plays a dominant role in the successful accomplishment of the Air Force medical mission. He is the family physician whose broad general knowledge provides a balanced medical capability, and whose close patient-doctor relationship with Air Force men and their families provides dividends not measurable by statistics.

The Air Force General Practice Residency Program provides one year of training in medicine, including pediatrics and psychiatry; and one year in surgery, including traumatic surgery, fractures, obstetrics and gynecology. It is expected the programs will be available at Andrews Air Force Base, Washington, D. C.; Keesler Air Force Base, Mississippi; and Wright Air Force Base, Ohio.

After completing residency training in general practice, medical officers may attend the primary course in aviation medicine, if they so desire, and are physically qualified.

Physicians interested in an Air Force career in general practice may write to The Surgeon General, Headquarters, USAF, Washington 25, D. C.

Obituaries • • •

DR. JOSEPH L. DIAS

For many years a prominent figure in New Jersey otolaryngology, Dr. Joseph L. Dias died in retirement in Florida on September 3. Born in Massachusetts in 1880, Dr. Dias received his M.D. from Columbia University's College of Physicians and Surgeons in 1903. After an internship in Brooklyn, he moved to Newark where he established an office for general practice. Dr. Dias became increasingly interested in ophthalmology and otolaryngology and was one of the early specialists in those fields. For several decades he served that department in the St. Barnabas Hospital in Newark. He was also on the staff of the New York Eye and Ear Infirmary. Dr. Dias was an emeritus member of the Essex County Medical Society.

DR. DAVID P. EVANS

Death came on July 14 to Dr. David P. Evans, senior attending pediatrician at the Orange Memorial Hospital. Dr. Evans was born in 1899 and was graduated in 1926 from the Medical School of the University of Virginia. He first came to New Jersey in 1927 as a resident in pediatrics at the Jersey City Medical Center. Shortly thereafter he moved to East Orange where he established his practice.

He was active in the American Academy of Pediatrics and in the Essex County Medical Society. He was also a member of the Orange Mountain Medical Society. During the war he was a Commander in the medical corps of the Navy.

DR. MORRIS JOELSON

Last year Dr. Morris S. Joelson of Paterson was one of the thirteen Passaic County physicians to receive a Golden Merit Award of The Medical Society of New Jersey. On August 19, Dr. Joelson died at his summer home in Deal at the age of 74.

Dr. Joelson is said to have delivered more than 20,000 babies in a career which spanned half a century. He received his M.D. degree from the College of Physicians and Surgeons at Columbia University in 1906 and came to Paterson, where he opened an office for general practice. In 1915 he joined the staff of Barnert Hospital.

In 1955 almost a thousand residents of the Paterson area celebrated Dr. Joelson's fortieth anniversary as an obstetrician. These celebrants were all "babies" who had been delivered by Dr. Joelson in the previous 40 years.

The Barnert Memorial Hospital has a waiting room for expectant fathers named for and dedicated to Dr. Joelson.

Dr. Joelson was a trustee of the Medical School of Hebrew University. He was active in the affairs of the Passaic County Medical Society. For many years he was obstetrician to the Barnert Memorial Hospital and more recently was consultant and emeritus obstetrician to that institution.

DR. FREDERICK W. SELL

On July 9 Dr. Frederick W. Sell of Rahway died at the Alexian Brothers Hospital in Elizabeth at the age of 88. Dr. Sell was the son of an English missionary in India and was born in that subcontinent in 1870. In 1874 he was brought to England where he attended Cambridge University and received his medical degree from Cambridge in 1894. Two years later he crossed the ocean and opened his office in Rahway.

He was medical director of the N. J. State Prison Farm at Rahway and he was health officer for the City of Rahway for many years. He was also active in public health work and was one of the earliest bacteriologists in New Jersey. He was widely known as the developer of a bacterial treatment for water supplies which was widely copied in other municipal plants in the country. He was a member of the medical corps of the Army of the United States in World War I.

Dr. Sell was the senior member of the Rahway Rotary Club. He was active in the work of the American Public Health Association. Dr. Sell began to restrict his work to radiology shortly after World War I, and he became a diplomate in radiology in 1941.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Current Therapy 1958. Edited by Howard F. Conn, M.D. Philadelphia 1958. Saunders. Pp. 827. ($12.00)

The cavalcade of modern drugs makes it hard for the practitioner to make a swift and effective selection of a remedy. To help him, several types of reference volumes have been developed. This is the fattest of such books running to 827 king-sized pages. However, few words are wasted. The arrangement is by lesion. Under each diagnosis is a capsular method of therapy—not just drugs, but surgical, manipulative, radiologic and even psychotherapeutic methods. The book is complete in itself, and is not just a supplement to the 1957 edition. It includes some brand-new material, particularly with reference to sulfonamides, diuretics, antihypertensives, and anticholinergic drugs. The problem of fluid control, electrolyte imbalance and parenteral administration is given monographic treatment in a compact section by Harry Weisberg. More than 140 authorities have contributed material to this book.

The appendix includes a somewhat incomplete roster of new drugs, an easy-reference table of pediatric posology, a conversion table of weights and measures, formulations for making percentage solutions, and a valuable list of normal laboratory values. (Who can remember the figure for normal creatinine tolerance, thymol turbidity, copper content of the urine, or proportion of free fatty acid in the stool?). The book is concluded with a profuse, practical index.

To anyone in clinical practice, this big volume is easily worth shelf space or, better, desk space.

VICTOR HUBERMAN, M.D.

A Primer on Common Functional Disorders. Jack W. Fleming, M.D. Boston 1958. Little, Brown and Company. Pp. 174. ($5.00)

Almost every medical practitioner now accepts the fact that there is an emotional component to physical illness. Many have carried this to the next step: if emotions can cause bodily mischief, emotions can also heal. Here, however, is the point of breakdown. When the general practitioner or internist wants to implement his psychosomatic philosophy he often finds himself trapped in a semantic jungle of psychiatric concepts that are hard to believe, understand or translate into action. And now Dr. Fleming comes to his rescue.

This *Primer* explains the emotional components in a variety of common disorders: headache, obesity, peptic ulcer, the hyperventilation syndrome, irritable colon, allergies and others. The explanatory text is salted with humorous but apt cartoons—which are to be used by the physician in explaining to a patient. The cartoons also help explain the relationship to the physician. The chapter on treatment is practical, free of platitudes, and sound. Dr. Fleming recognizes the point at which the nonpsychiatric physician may get to feel uncomfortable, but gives enough material so that the practitioner can understand the next step even if he refers the patient to a psychiatrist to apply it. There are, today, several psychotherapy texts for general practitioners, and this is one of the most usable. It goes far towards taking the voodoo out of psychotherapy.

ABRAHAM LEFF, M.D.

Dietary Prevention and Treatment of Heart Disease. By J. W. Gofman, M.D., A.V. Nichols, Ph.D., and E. V. Dobbin. New York 1958, Putnam. Pp. 256. ($3.95)

This compact, easily readable text is unique in the field of the dietary prevention and treatment of heart disease. It aims at an audience of intelligent laymen and physicians interested in the preventive medicine aspect of heart disease. The first six chapters are concerned with the nature of coronary artery disease, the dietary fat and carbohydrate intake, the role of calories and of obesity, and the evaluation of a diet. The second part consists of a series of chapters in which the patient's present diet can be altered to a recommended one. Abundant recipes and cooking hints are included.

The authors' discussion of the nature of coronary artery disease is excellent, and provides in easily understandable language a review of the physiology of the cardiovascular system, and of the pathology of coronary artery disease. The review of the roles of lipoproteins of S(f) values 0-12, 12-20, 20-100 and 100-400 is quite up to date. The authors feel that every patient ought to have a blood lipoprotein analysis. If raised values of any of the four lipoprotein divisions are found, they recommend a conscious effort to utilize a diet containing little if any of the offending fraction. It would seem that such a theory is somewhat premature and presumptive at this time. Nevertheless, this book fulfills a need, and will prove especially of value to dieticians and to housewives interested in planning tasty dishes with low fat or carbohydrate content.

MAURICE J. ZIMMERMAN, M.D.

TUBERCULOSIS Abstracts

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Vol. XXXI October, 1958 No. 10

Resection for Pulmonary Tuberculosis

A Four-Year Follow-up Study, *D. Bonta Hiscoe, M.D., William F. Thompson, M.D., Thomas J. Enright, M.D., and Harrison Black, M.D., The New England Journal of Medicine, May 1, 1958.*

● The long term results of resection for pulmonary tuberculosis are given detailed examination in a series of 80 cases.

During the past decade, the use of antituberculous chemotherapy in conjunction with pulmonary resection has revolutionized the treatment of pulmonary tuberculosis. As with any chronic disease, an evaluation of results can be considered significant only if a reasonable time has elapsed after treatment. Although there are exceptions, the majority of cases reported have been followed for a very short period. As a result the validity of the conclusions may be open to question. More protracted studies have shown that late reactivations after resection are not uncommon.

In the present study only cases which were followed for a minimum of four years have been considered. To adhere to this requirement it has been necessary to consider patients treated in an era when the number of antituberculous drugs was limited, and their proper use not well understood. In addition, previous collapse therapy was employed more frequently among these patients than in current candidates for resection.

General Statistics. All cases in which pulmonary resection was performed at the Veterans Administration Hospital, Rutland Heights, Massachusetts, between January 1, 1949 and January 1, 1953, were reviewed. During this period 93 resections were performed on 89 patients. Nine cases were excluded from the study either because of inadequate information, or because bilateral resections had been done. Thus, the study group comprises 80 patients who underwent unilateral pulmonary resection. They had been followed for an average of five years and nine months (range of four years to seven years and ten months).

Age, Sex and Race. This group of patients is obviously not representative of the tuberculous population in general because of the requirements for admission to a Veterans Administration hospital. The great majority of these patients were young white males, between the ages of twenty and forty years.

Type of Disease. Many of the patients at the time of operation could not be classified as optimal candidates for surgery by contemporary standards. Of the 80 patients who underwent resection 42 had bilateral involvement, the contralateral disease being stable. Fifty-four resections were done for open lesions, and 12 for closed lesions, and in 14 the status of the cavity was indeterminate. More significant, however, is the fact that 62 of the 80 patients (77 per cent) had *positive sputum* either by culture or by smear within three months before operation.

Indications. Fifty-seven per cent of these patients were operated on for *stable residual lesions.* A lesion was placed in this category if no change was noted for three months or more on serial roentgenograms. A relatively high proportion (23 per cent) underwent resection for what was considered to be relatively *unstable cavitary disease,* which included all patients whose roentgenograms had changed within three months of the time of surgery. Twenty per cent had resection for thoracoplasty failure. The operation performed most frequently was lobectomy.

Chemotherapy. It is important to stress the fact that, although only four years have elapsed since the last of these resections were performed, the philosophy of treatment has changed drastically during this time. During the period of this study the chemotherapy consisted for the most part of streptomycin, usually used with para-aminosalicylic acid. The use of chemotherapy was erratic, some patients receiving long, and others short

courses. Most patients were given more chemotherapy postoperatively than pre-operatively.

Prior Collapse Therapy. A relatively large number of patients had received collapse therapy before resection. Fifty-two patients (65 per cent) had had pneumothorax, pneumoperitoneum or thoracoplasty in various combinations. Eighteen had undergone thoracoplasties, 2 of which were contralateral. *Postoperative thoracoplasty* was used more often between 1949 and 1952 than is the case today. In this series of 80 operations, 45 were followed by thoracoplasties, 23 of which were done to prevent over-expansion of the remaining lung, and not for specific complications.

Result at Four Years According to Groups. There were 80 patients who had resectional surgery for tuberculosis and have been followed for four years or more. The 12 patients who showed evidence of activity within six months of operation were considered to have persistence of their disease. Activity appearing after six months was considered a relapse (4 patients). In most cases the criterion of activity was a positive sputum by smear or culture, but in five patients there was radiologic or clinical evidence of activity in the absence of bacteriologic confirmation.

DISCUSSION

At present 85 per cent of the patients are well and have negative sputum. Only 72 per cent of patients obtained a good result without the necessity of further treatment.

The value of long-term follow-up study is apparent when the bacteriologic relapses are analyzed. Fifteen patients had occasionally positive sputum within the first 18 months after surgery, but in none did a clinical relapse occur. In other words, if these patients are followed long enough, many will achieve a good bacteriologic as well as clinical result.

There were several factors that were unfavorable for elective resectional surgery in the group studied. Nevertheless, 85 per cent of the patients are well, physically active and working or able to work. Even in the presence of a positive sputum satisfactory results were obtained in 69 per cent. The comparative figure for those with a negative sputum is 88 per cent.

The difference in results as related to extent of disease is striking. Ninety-two per cent of the patients with unilateral disease had a satisfactory result, as compared with only 52 per cent of those with bilateral disease.

Resections for unstable cavitary disease yielded fewer satisfactory results than when the resection was performed for a stable residual lesion.

A prompt conversion to negative after surgery as well as a negative sputum pre-operatively was associated with a high expectation of a good long-term result.

The fact that chemotherapy at the time of surgery has a striking effect on end results is well known. The patients who received more than 30 days of pre-operative chemotherapy and more than 180 days of total chemotherapy had the best results.

SUMMARY AND CONCLUSIONS. A series of 80 resections for pulmonary tuberculosis performed between January 1, 1949 and January 1, 1953, is presented.

Eighty-five per cent of the patients are well and have negative sputum. All survivors have been followed for a minimum of four years.

The majority of poor results were evident within eighteen months of resection.

Seventy-seven per cent of the patients had positive sputum at the time of surgery, and the poor results were concentrated heavily in this group.

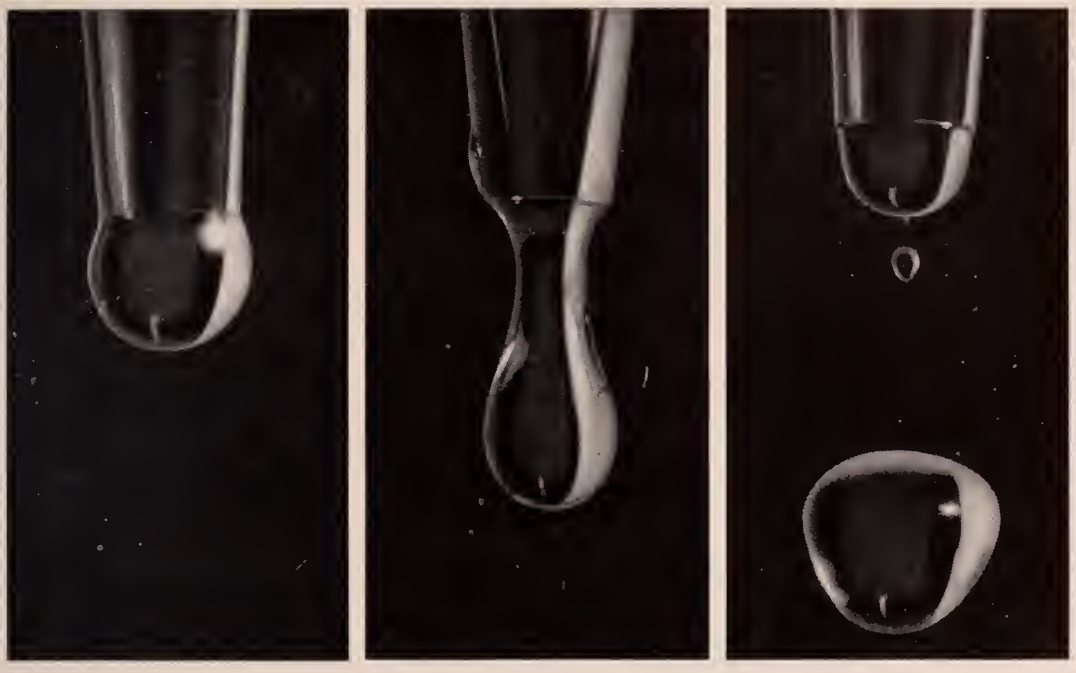
All of the tuberculous complications occurred in open-positive cases, and almost a third of such patients had major complications.

A study of the chemotherapeutic regimens further substantiates the importance of adequate pre-operative and total drug coverage for resectional surgery.

Postoperative thoracoplasty did not appear to alter results favorably unless done for a specific complication.

The factors that were correlated with a good long-term result were as follows: unilateral disease; a stable residual lesion; negative sputum pre-operatively; pre-operative chemotherapy for thirty days or more; total chemotherapy for a hundred and eighty days or more; and prompt conversion to negativity postoperatively.

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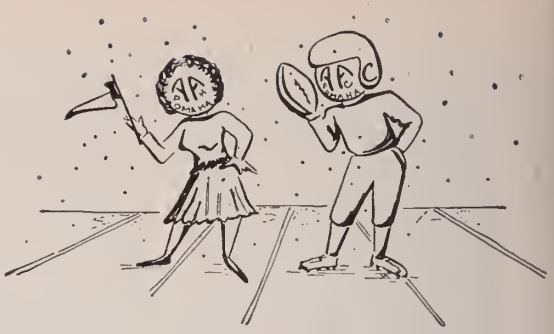
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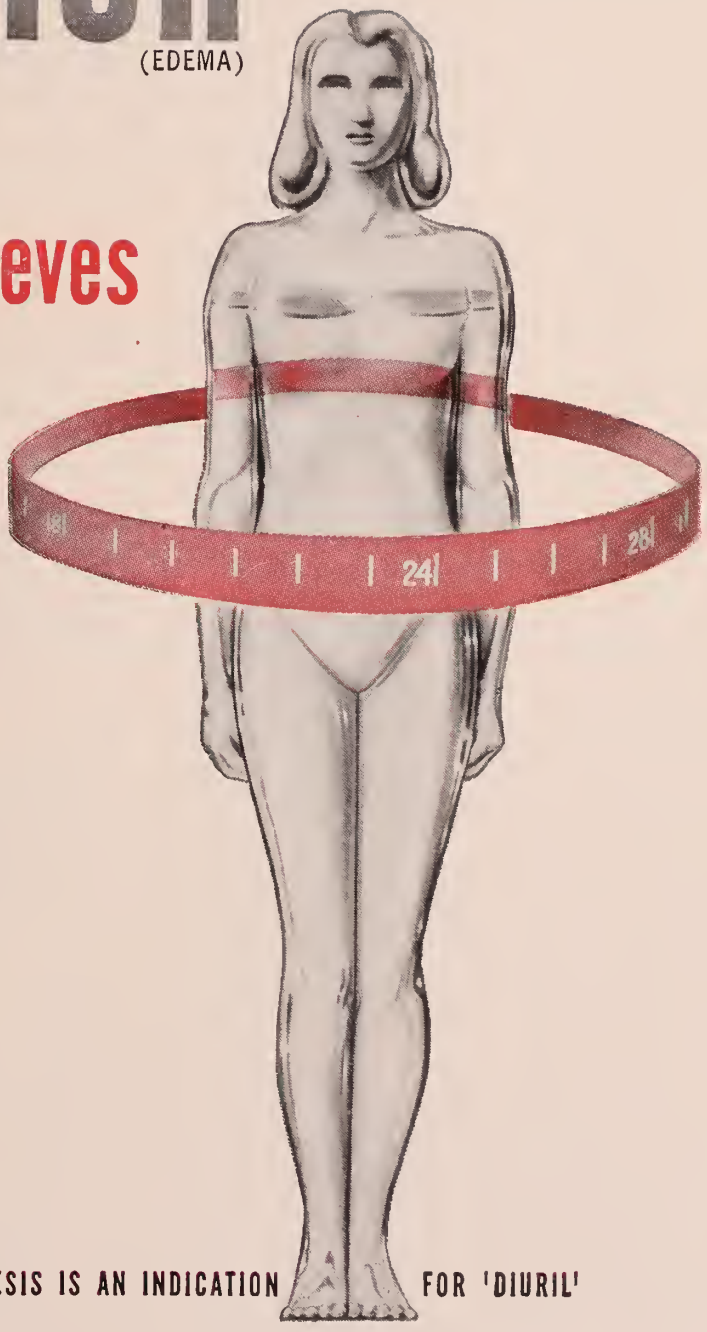
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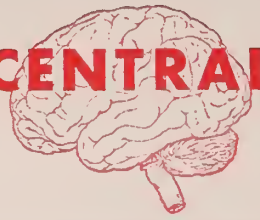
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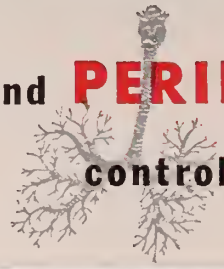
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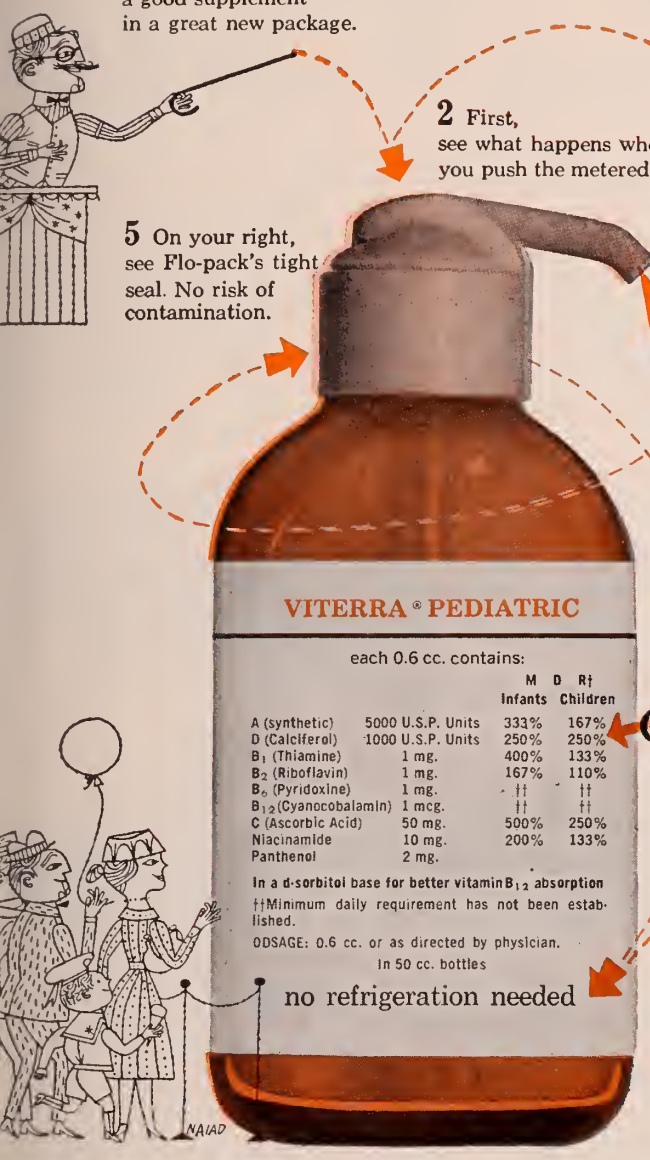
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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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2. Editorial: *New England J. Med.* 258:48-49, 1958.

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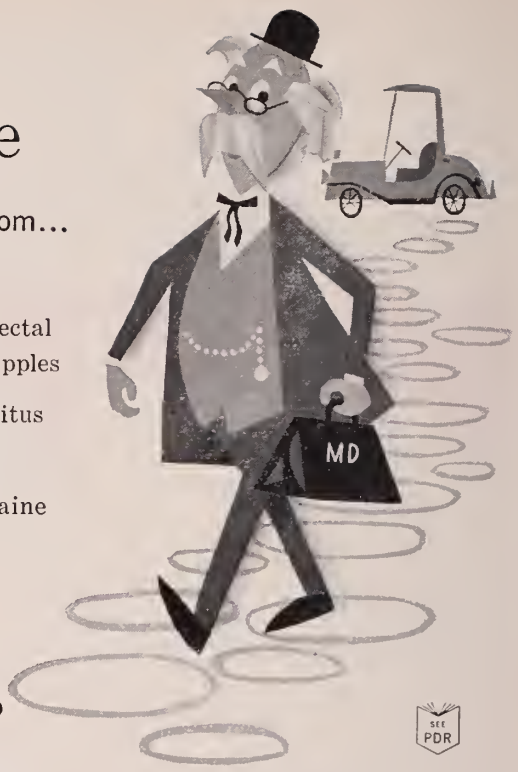
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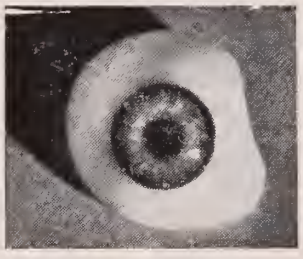
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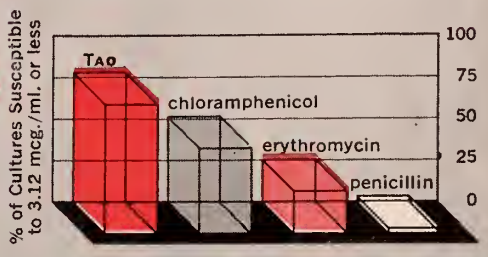
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CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
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Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
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Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

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References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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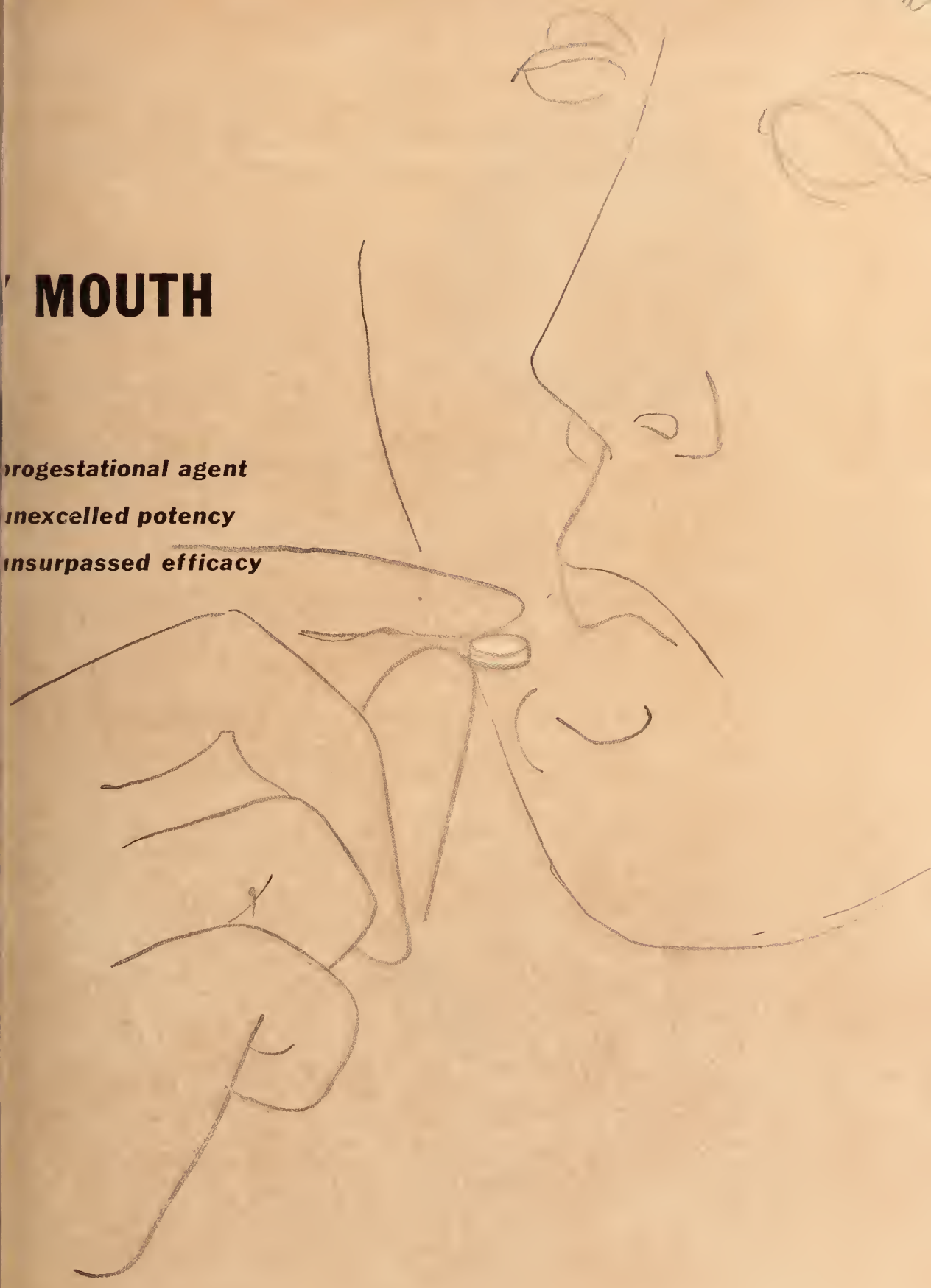
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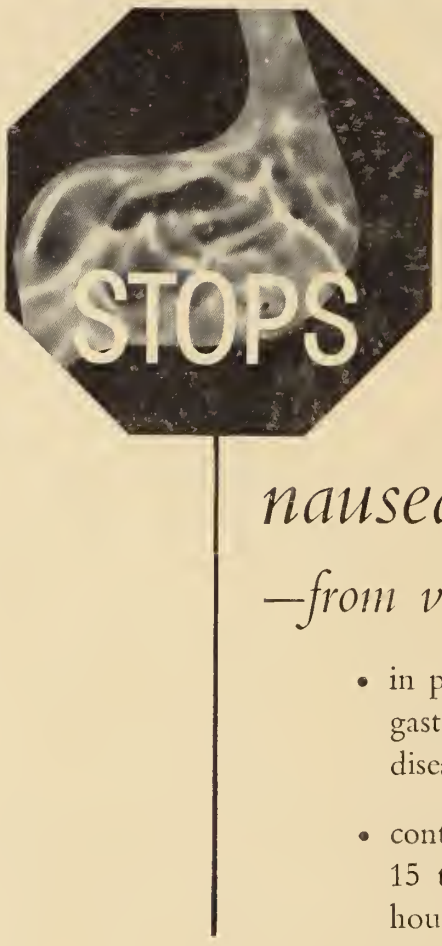
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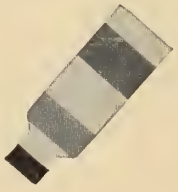
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now—an antibiotic troche that

STOPS COUGH TOO





The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

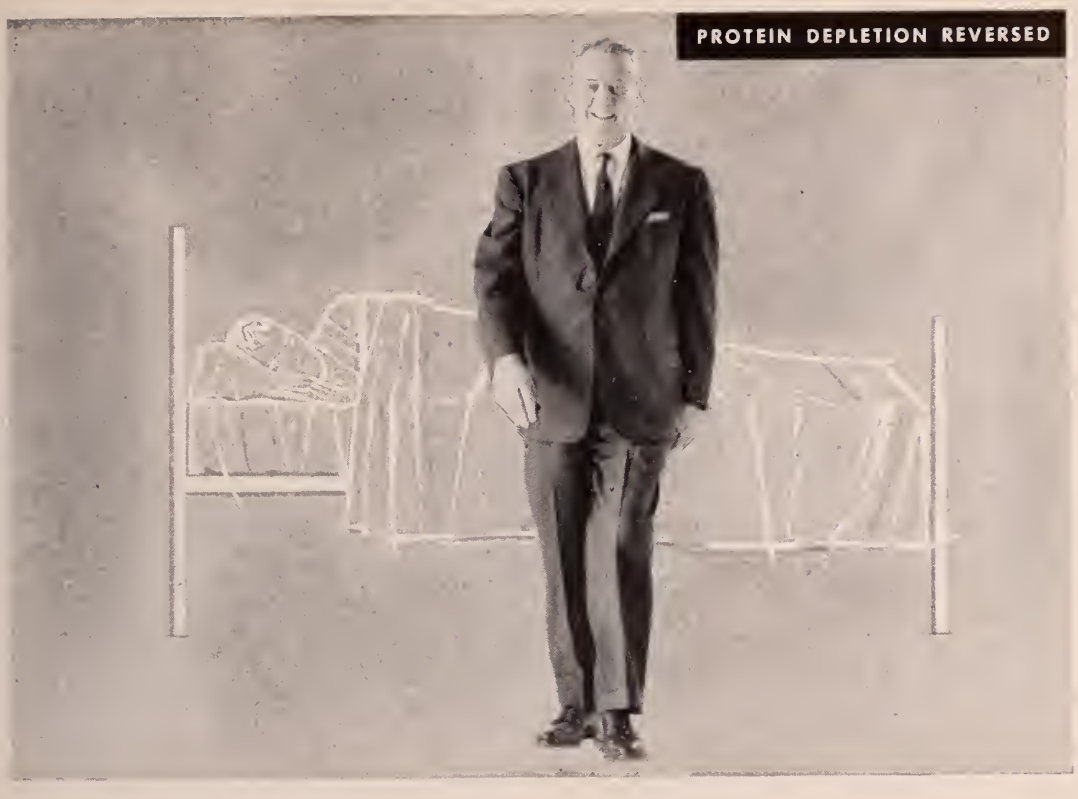
PRESCRIBE

Pentazets®

antitussive—antibiotic-anesthetic—analgesic troches

MSD MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.



the clinical results are **positive** when

NILEVAR® restores positive nitrogen balance

The anabolic effects of Nilevar are quickly manifest both to the patient and to the attending physician.

When loss of nitrogen delays postsurgical recovery or stalls convalescence after acute illness and in severe burns and trauma, Nilevar has been found to effect these responses:

- **Appetite improves**
- **Weight increases**
- **The patient feels better**
- **The patient recovers faster**

Similarly Nilevar helps correct the "protein catabolic state" associated with prolonged bed rest in carcinomatosis, tuberculosis, anorexia nervosa and other chronic wasting diseases.

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent in appropriate dosage.

Nilevar (brand of norethandrolone) is supplied as tablets of 10 mg. and ampuls (1 cc.) of 25 mg. The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

SEARLE Research in the Service of Medicine.
G. D. SEARLE & CO., CHICAGO 80, ILLINOIS



Hospital practice of infant feeding

Self-regulated schedules

The newborn may become a feeding problem if the formula is excessive or if he is awakened to be fed forcefully.

The young infant may balk at new food or procedure. The older infant, devoted to his bottle, may resent weaning—it takes a certain readiness for weaning to make the change agreeable. Later, the infant may become somewhat independent and arbitrary—what he enjoyed yesterday he rejects today.

When a feeding problem is in the making, sensible decorum will solve it. Nature invites infant feeding cooperation through hunger. If hunger is appeased on demand rather than by clock there will be fewer problems—the baby is the best judge of when he wants food and how much.

Feeding must be adapted to the infant individually to make it a pleasurable experience. This is the current objective in successful infant feeding formulated for normal infants in the charts below:

WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760
12	32	9	0	8	5	640

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764
12	16	16	0	8	4	704

ADVANTAGES OF KARO® SYRUP IN INFANT FEEDING

Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no digestion.



Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

Free to Physicians—Book of Infant Feeding Formulas with convenient schedule pads. Write: Karo Infant Feeding Guide, Box 250, New York 46, N. Y.

CORN PRODUCTS REFINING COMPANY

Now—the most widely prescribed tranquilizer[1] in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules



q. 12 h.

Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained* basis, without between-dose interruption

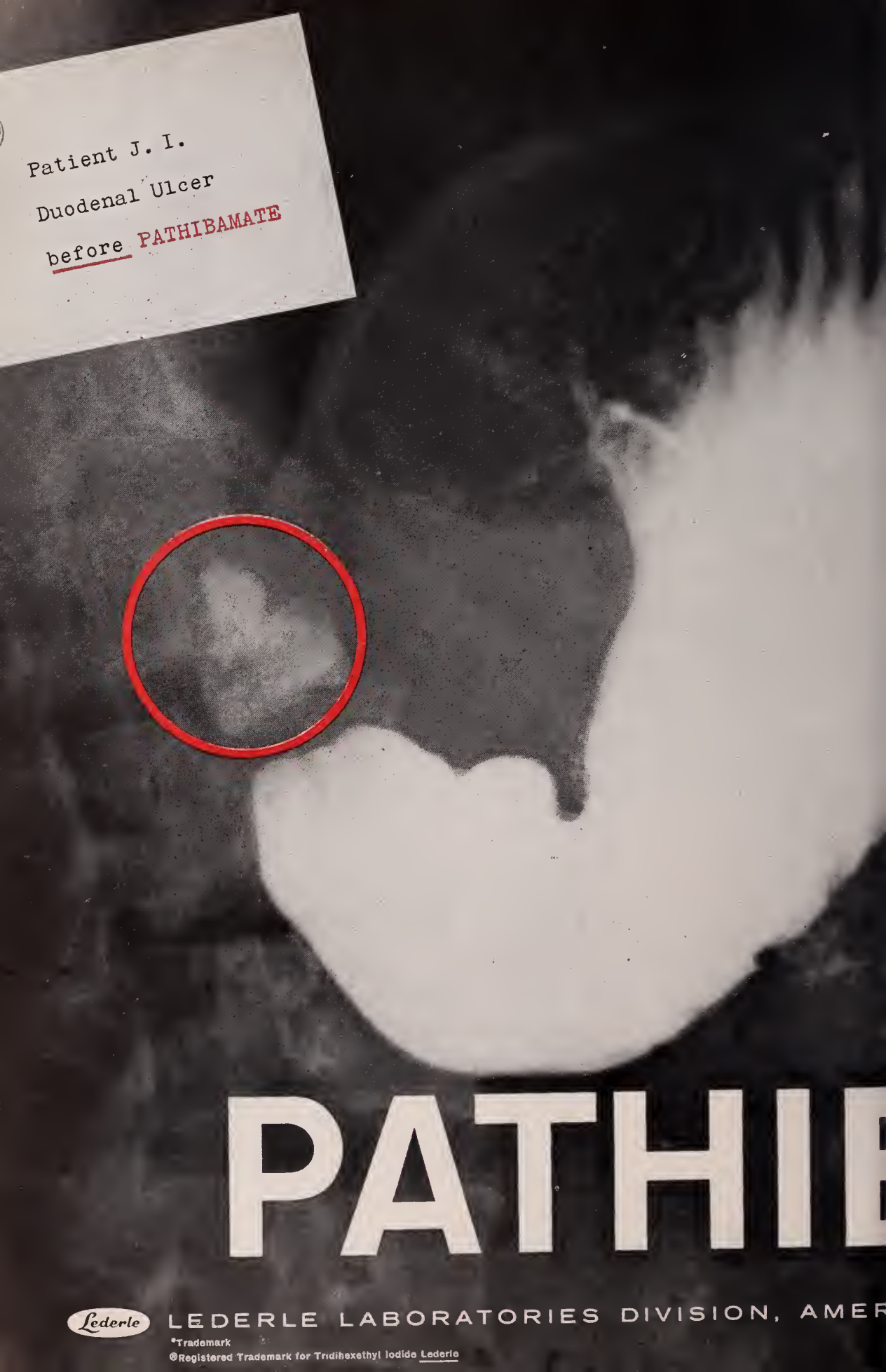
"The administration of meprobamate in sustained action form [Meprospan] produced a more uniform and sustained action . . . these capsules offer effectiveness at reduced dosage."[2]

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

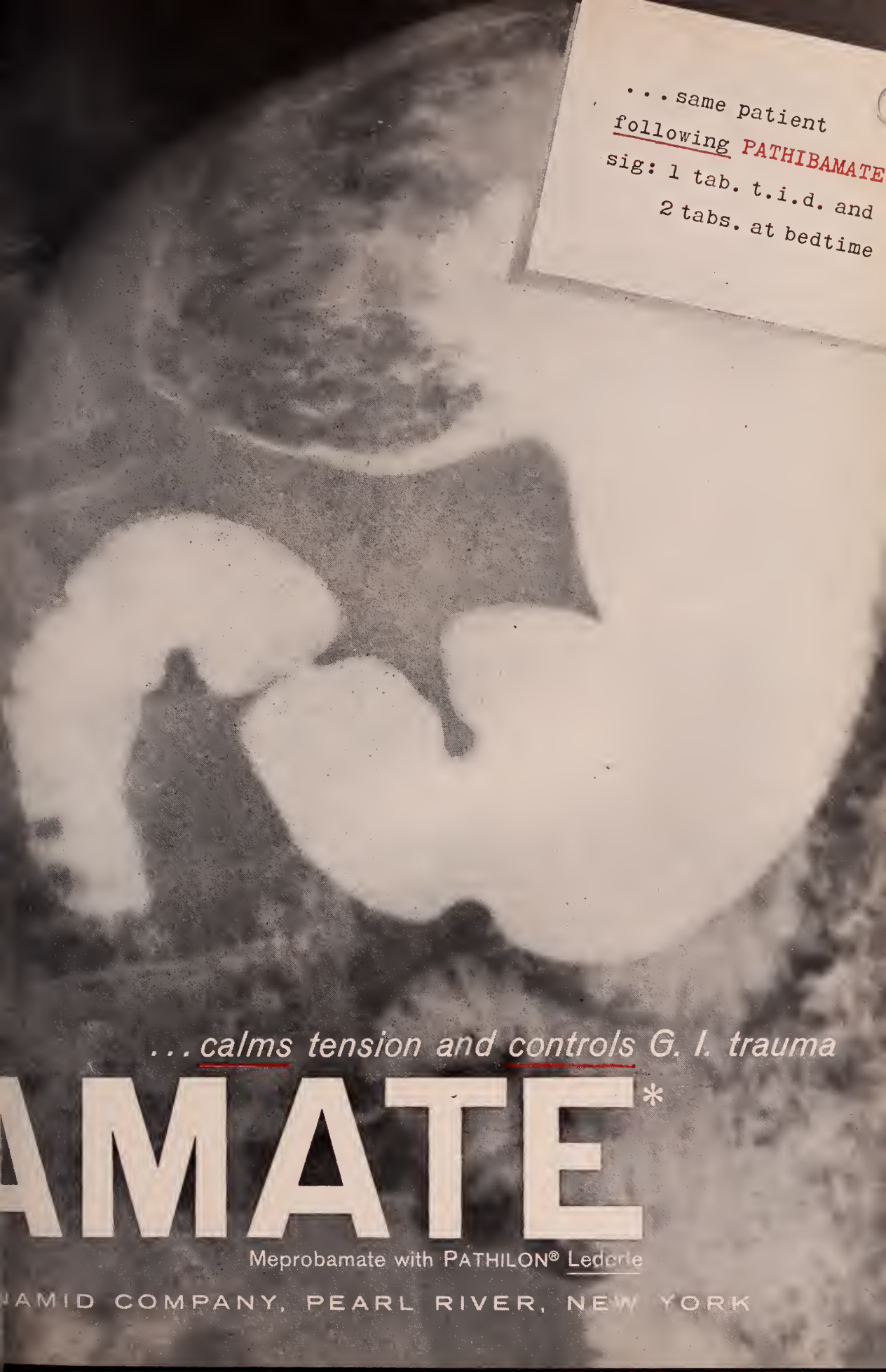
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*Trademark

®Registered Trademark for Tridihexethyl Iodide Lederle


. . . same patient
following PATHIBAMATE
sig: 1 tab. t.i.d. and
2 tabs. at bedtime
. . . calms tension and controls G. I. trauma
AMATE*
Meprobamate with PATHILON® Lederle
AMID COMPANY, PEARL RIVER, NEW YORK

NEW styling
for known standard

To diabetics and their physicians, CLINITEST means rapid *and* reliable urine-sugar testing—standardized for accurate results every time. And now, the new streamlined model (No. 2105) gives your diabetics this standard test in the best looking, most efficient form.

CLINITEST®
BRAND

urine-sugar analysis set

- **functional:** full-view test tube always in place
- **refillable:** takes either bottle of 36 or sealed-in-foil CLINITEST reagent tablets
- **attractive:** two-tone, neutral gray plastic case

Model No. 2105 CLINITEST Urine-Sugar Analysis Set contains everything needed for accurate standardized testing: bottle of 36 CLINITEST Reagent Tablets, test tube, unbreakable dropper. color scale—instruction sheet, analysis record, diabetic's identification card



MODEL NO. 2105

AMES COMPANY, INC · ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

S6758

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

'TABLOID'

'EMPIRIN' COMPOUND®

WITH

CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Symbo

OF

PROVE

PAIN

RELIE



gr. 1



gr. ½



gr. ¼



gr. ⅛

Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*



Codeine Phosphate . . . . . gr. ¼
Phenobarbital . . . . . gr. ½
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3

'CODEMPIRAL'® NO. 2*



Codeine Phosphate . . . . . gr. ¼
Phenobarbital . . . . . gr. ½
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3

...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

'TABLOID'

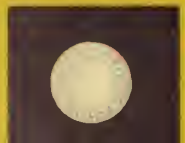
'EMPIRIN' COMPOUND



Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½
Caffeine . . . . . gr. ½

...from mild pain complicated by tension and restlessness.

'EMPIRAL'®



Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

*Subject to Federal Narcotic Regulations

whenever
he
starts
to



he's
ready
for

Delectavites®

New vitamin-mineral supplement
in delicious chocolate-like nuggets



There's nothing easier to give
or take—
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

Each nugget contains

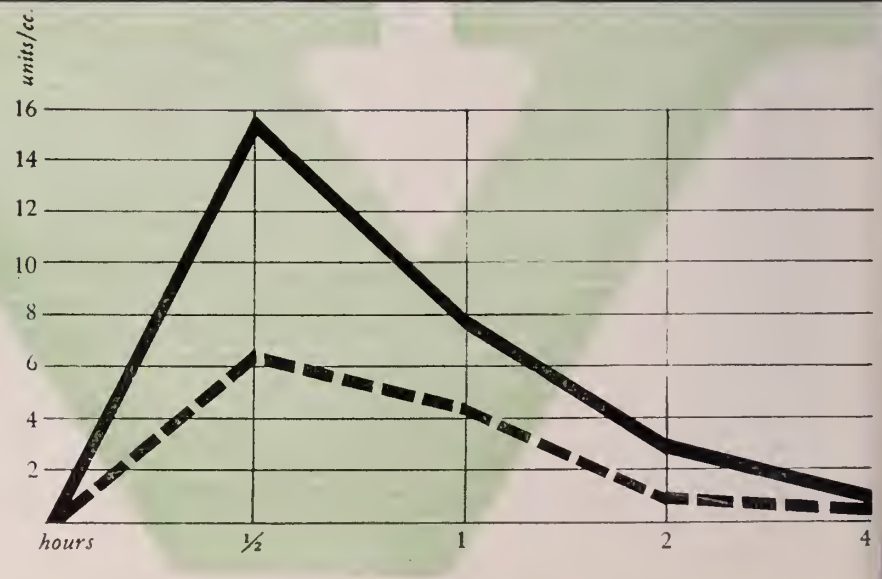
Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Base Supplied: One Nugget per day
Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.

WHITE LABORATORIES, INC.,
KENILWORTH, N. J.

Compoc



The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

the higher
blood levels of
potassium
penicillin V

illin®-VK

potassium penicillin V

IN FILMTABS,
COMPOCILLIN-VK comes in 125 mg. (200,000 units), bottles of 50 and 100, and in 250 mg. (400,000 units), bottles of 25 and 100.

FOR ORAL SOLUTION,
COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry flavored, the granules are in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

IN FILMTAB®/ IN ORAL SOLUTION

Abbott



Functional and Organic Control

of *PEPTIC ULCER*

Gastrointestinal Irritability and Tension

MONODRAL® with MEBARAL®

TABLETS

Potent ANTISECRETORY • ANTICHOLINERGIC • SEDATIVE

Each tablet contains:

Monodral bromide.....5 mg.
Mebaral.....32 mg.

PROVIDES:

Dependable control of hyperacidity and hypermotility. Spasmolysis. Prompt and prolonged pain relief and tranquillity.

DOSE:

Peptic ulcer, 1 or 2 tablets three or four times daily. Other gastrointestinal disorders, 1 tablet three or four times daily.

SUPPLIED: Bottles of 100 tablets.

For unsurpassed results in **PEPTIC ULCER** *prescribe* **Monodral** with **Mebaral** *in conjunction with*

Creamalin® PIONEER ALUMINUM HYDROXIDE GEL

- Fast Acting Reactive Gel
- Protective Coating

Creamalin liquid — 8 and 16 fl. oz.
Creamalin tablets — bottles of 50 and 200.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Manodral (brand of penthienate), Mebaral (brand of mephobarbital), and Creamalin, trademarks reg. U.S. Pat. Off.



if you were
in the rheumatoid arthritic's shoes,
Doctor...

wouldn't you want a steroid
with a proved record
of safety and success?

METICORTEN®

prednisone

you can count on rapid relief from pain, swelling and stiffness followed by functional improvement and maintained on an uncomplicated, low-dosage regimen with minimal chance of side effects† and without unexplained weight loss, anorexia, muscle cramps as reported with certain other corticoids†

†Round-table Discussion by Leading Investigators, San Francisco, Calif., June 20, 1958.

Schering

METICORTEN, 1, 2.5 and 5 mg. white tablets.

SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY

MC-J-2268


DOCTORS
PARKING
ONLY
7AM - 7PM
QUIET



ACHROMYCIN® V

Tetracycline and Citric Acid Lederle

A Decision of Physicians

When it comes to prescribing broad-spectrum antibiotics, physicians today most frequently specify ACHROMYCIN V.

The reason for this decided preference is simple.

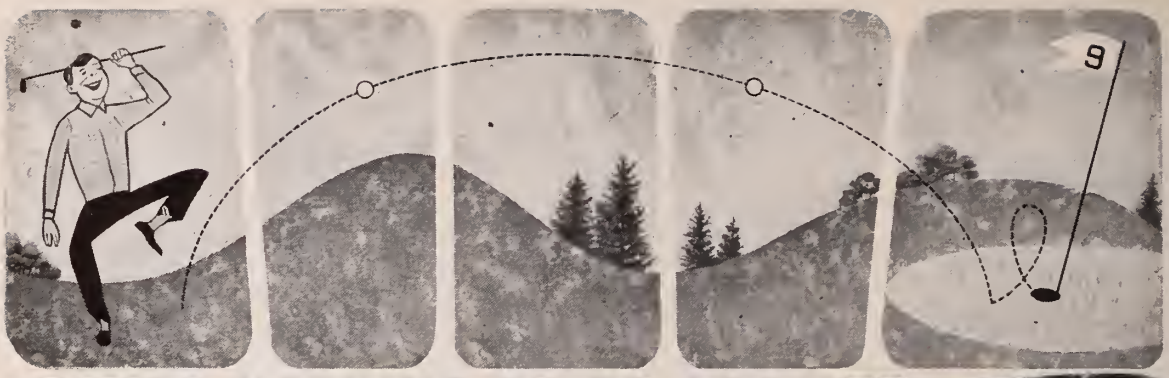
For more than four years now, you and your colleagues have had many opportunities to observe and confirm the clinical efficacy of ACHROMYCIN tetracycline and, more recently, ACHROMYCIN V tetracycline and citric acid.

In patient after patient, in diseases caused by many invading organisms, ACHROMYCIN achieves prompt control of the infection—and with few significant side effects.

The next time your diagnosis calls for rapid antibiotic action, rely on ACHROMYCIN V—the choice of physicians in every field and specialty.

Lederle

LEDERLE LABORATORIES
a Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York



LEAVES NOTHING TO BE DESIRED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and related symptoms in 15-20 minutes
- effective for 6 hours or longer • promotes expectoration
- rarely constipates • cherry-flavored

Each teaspoonful (5 cc.) contains:

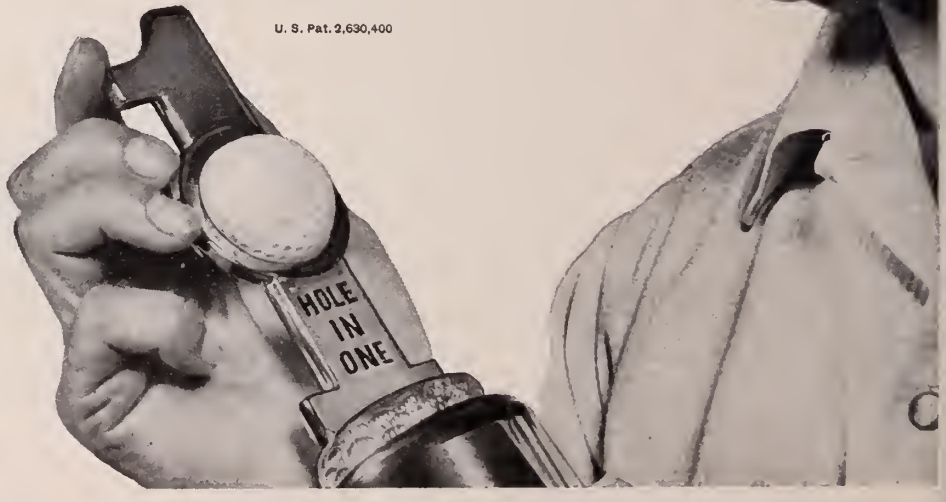
Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Adult Dosage: one teaspoonful q. 6 h. May be habit-forming.
Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES
Richmond Hill 18, New York



U. S. Pat. 2,630,400

SAFETY FIRST



filmtab®

Erythrocin®

STEARATE (ERYTHROMYCIN STEARATE, ABBOTT)

AFTER SIX YEARS, A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY—PLUS REMARKABLE EFFECTIVENESS AGAINST THE COCCI

Actually, after all this time, there has not been a single, serious reaction to ERYTHROCIN. Also, the problem of resistance has remained unusually low.

You'll find ERYTHROCIN highly effective against most coccal organisms. And it may well be the tool to counteract coccal complications following viral attacks.

Usual adult dose is 250 mg. four times daily. Dosage for children may be reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also available in tasty, cinnamon-flavored oral suspension; comes in 75-cc. bottles.

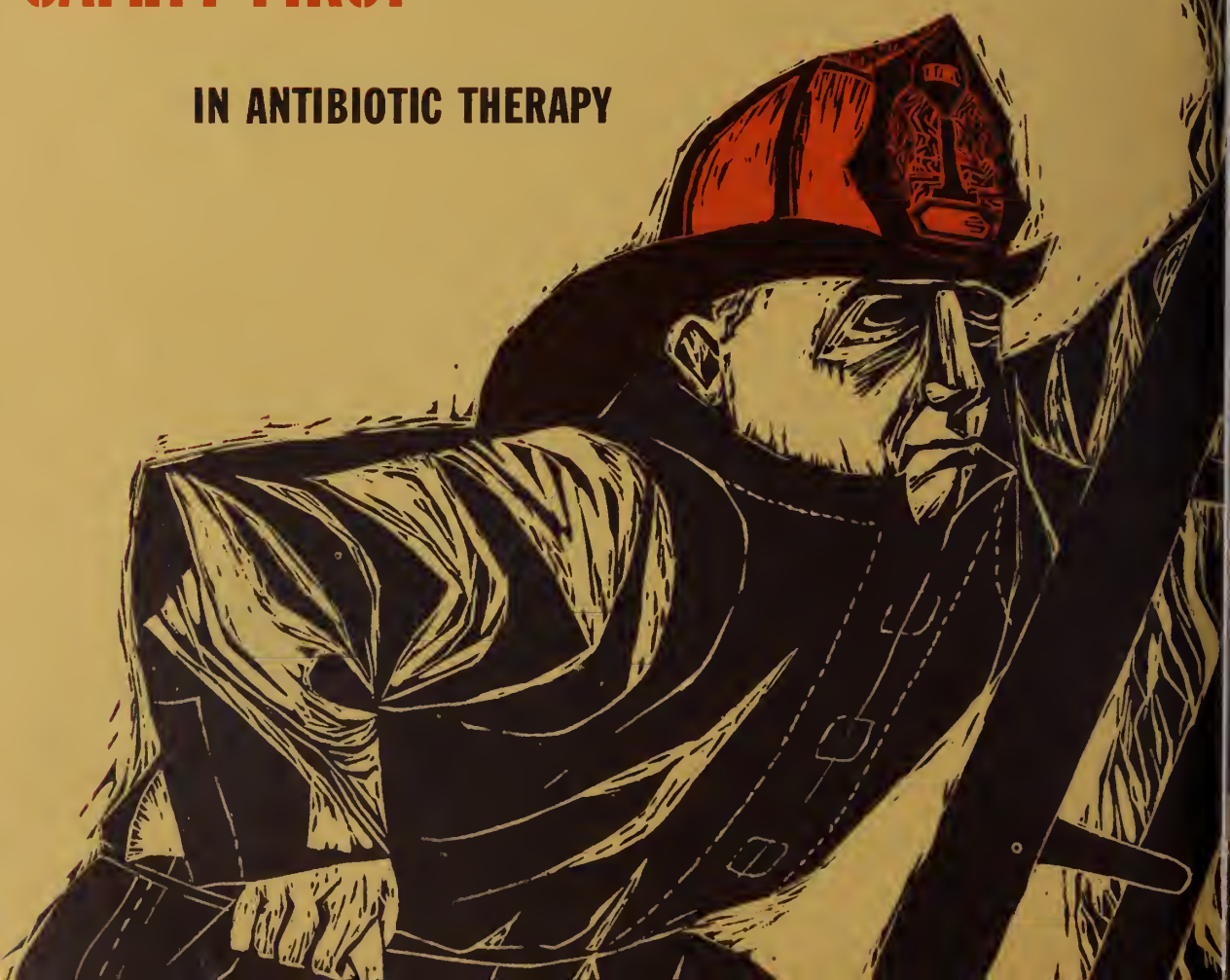
Abbott

® FILMTAB—FILM-SEALED TABLETS, ABBOTT; PAT. APPLIED FOR.

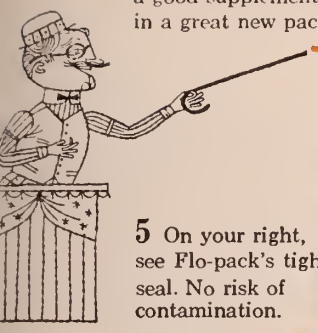
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SAFETY FIRST

IN ANTIBIOTIC THERAPY



1 Ladeez and gentlemen:
learn all about new VITERRA PEDIATRIC,
a good supplement
in a great new package.



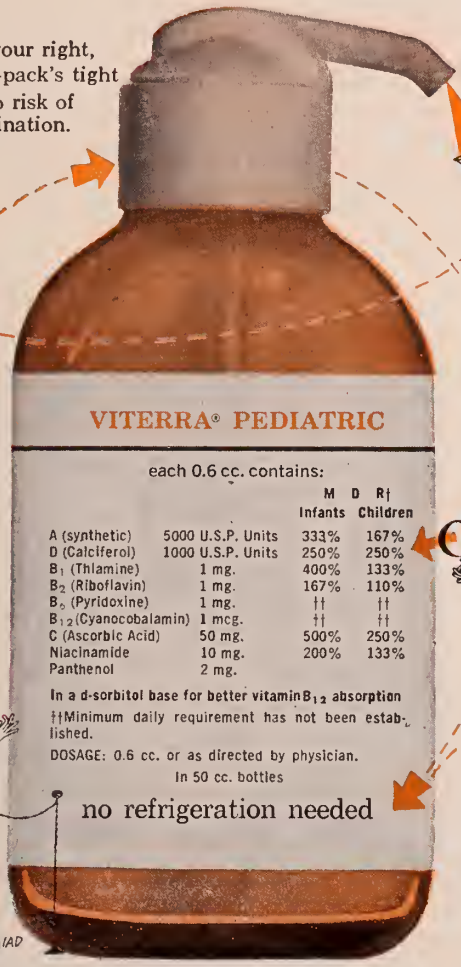
2 First,
see what happens when
you push the metered plunger.

3 Aha!
An exact 0.6 cc.
comes out this spout.
Never more, never less.



4 And notice —
no drip, no waste,
no sticky bottle.

5 On your right,
see Flo-pack's tight
seal. No risk of
contamination.



6 Let's take a minute
to admire the formula.





7 *That* means
no hot-weather
loss of potency.



8 Now for a farewell treat, a taste of delicious, orange-y VITERRA PEDIATRIC. How will you have it — in fruit juice? On cereal? Straight from the spoon?

VITERRA® PEDIATRIC



METERED FLO-PACK

Special note to doctors who took this tour:

Problems of over- and under-dosage, spillage, spoilage or leakage disappear with VITERRA PEDIATRIC'S new metered Flo-pack. Why not consider these advantages when you recommend a vitamin supplement?

Roerig NEW YORK 17, N.Y. Division, Chas. Pfizer & Co., Inc.
SCIENCE FOR THE WORLD'S WELL-BEING

Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

c

Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

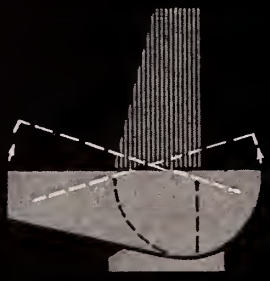


MEPROLONE is a trade-mark of Merck & Co., Inc.

probably the easiest-to-use x-ray table in its field



Instant swing-through from fluoroscopy to radiography (and vice versa). Self-guiding to correct operating distance. Nothing to match up . . . you do it without leaving the table front.

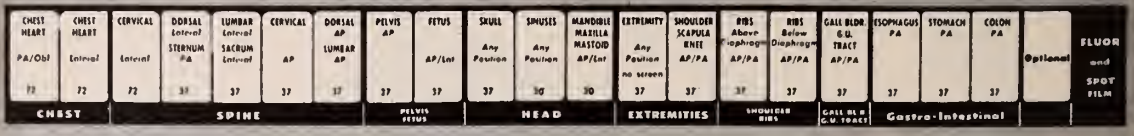


Horizontal, vertical, intermediate, or Trendelenburg positions by equipoise handrock (or quiet motor-drive).



Choice of rotating or stationary anode x-ray tubes. Full powered 100 ma at 100 KVP.

certainly the simplest automatic x-ray control ever devised



know why? *look* . . .

1. On this board you select the bodypart you want to x-ray
2. Set its measured thickness
3. Press the exposure button

That's all there is to it. No time, KV, or MA adjusting to do. No charts to check, no calculations to make.



housed in this handsome upright cabinet

obviously as canny an x-ray investment as you can make

Modest cost
Excellent value
Prestige "look"
Top Reputation (significantly, "Century" trade-in value has long been highest in its field)

And you can rent if you prefer.

Call in your Picker representative (he's probably in your local 'phone book) or write: PICKER X-RAY CORPORATION 25 South Broadway, White Plains, N. Y.

anatomatic Century
diagnostic x-ray unit

Picker



NEWARK 2, N. J., 972 Broad Street
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Matawan, N. J., 52 Edgemere Drive
Philadelphia 4, Pa., 103 S. 34th St.
(Southern N. J.)

for depression

Deprol†

Clinically confirmed in over 2,500 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation
► restores natural sleep
► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function
► causes no excessive elation
► produces no liver toxicity
► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia
► produces no amphetamine-like jitteriness
► does not depress appetite
► has no depression-producing aftereffects
► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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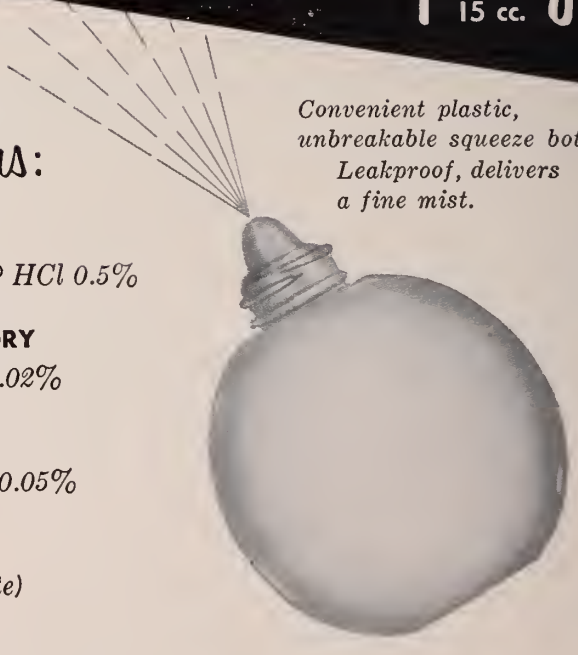
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References: 1. Spies, T. D., et
J.A.M.A. 159:645, 1955. 2. Spies, T
et al.: Postgrad. Med. 17:1, 1955
Gelli, G., and Della Santa, L.: Mine
Pediat. 7:1456, 1955. 4. Guerra,
Fed. Proc. 12:326, 1953. 5. Bu
E. A.: Clin. Med. 2:1105, 1955.
Sticker, R. B.: Panel Discussion, C
State M. J. 52:1037, 1956.

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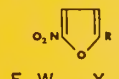
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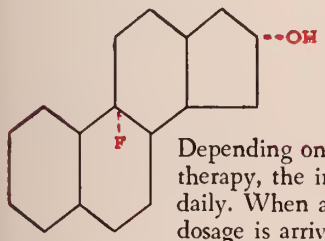
1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. *165*:1821, (Dec 7) 1957.
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4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
6. Schwartz, E.: Personal Communication.
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8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
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10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
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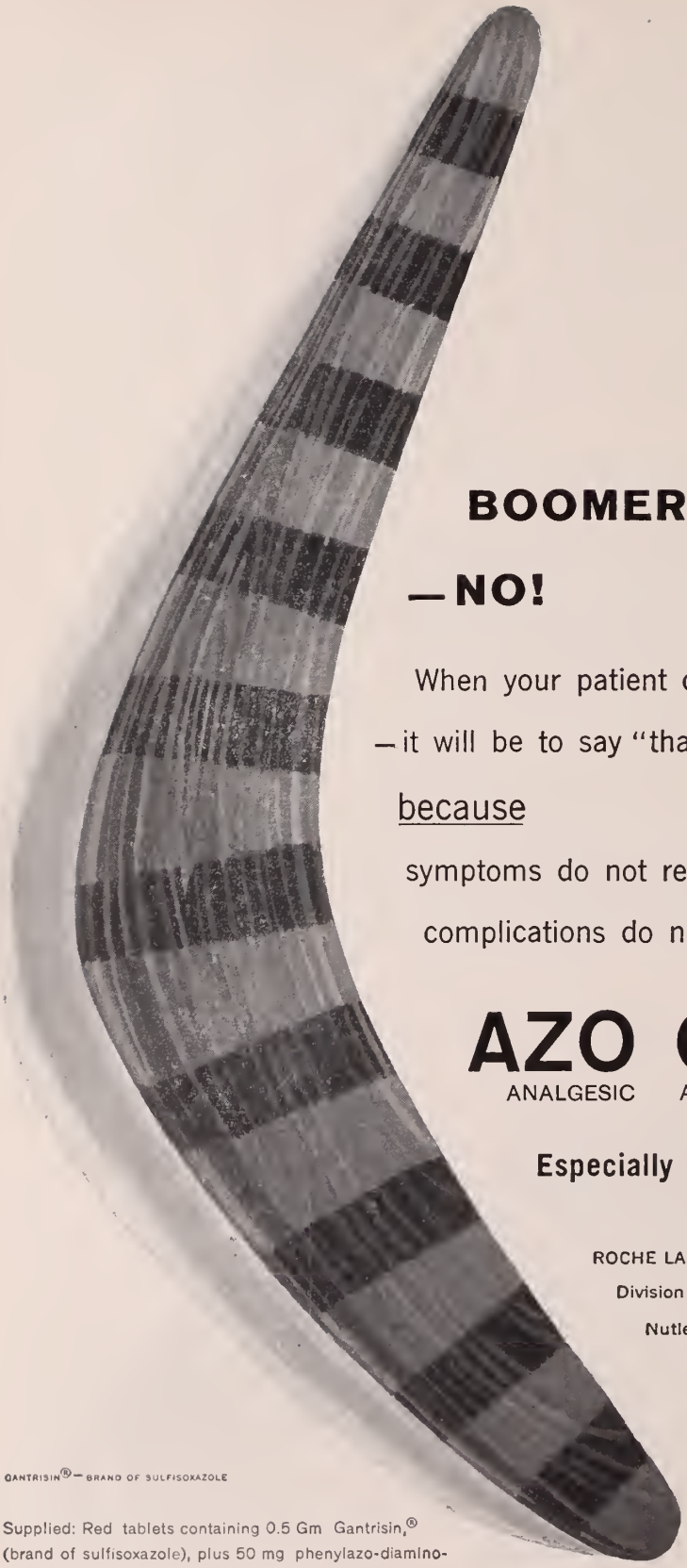


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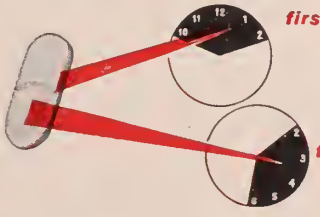
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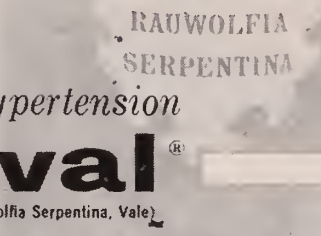
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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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	CALORIES FAT	CALORIES PROTEIN	CALORIES CARBO.	TOTAL CALORIES	CALORIES Not More Than	CARBOHYDRATES Not More Than
White Bread		10.6	57.0	67.6	1.0	1.0
Pineapple Pie	18.3	3.7	41.5	63.5	1.0	0.66
Apple Pie	25.0	4.3	43.5	72.8	1.2	0.7
Cheery Pie	21.6	3.5	43.0	68.1	1.1	0.7
Peach Pie	17.0	2.7	38.0	57.7	0.9	0.6
T. C. Cream Pie	42.5	12.5	36.5	91.5	1.5	0.6
Pineapple Horseshoe	63.5	8.5	47.0	119.0	1.9	0.7
Blueberry Horseshoe	56.0	9.0	55.0	120.0	1.9	0.8
Cherry Horseshoe	57.0	8.7	55.0	120.7	1.9	0.8
Apple Horseshoe	56.0	9.0	61.0	126.0	2.0	1.0
Pineapple Turnover	66.5	9.0	46.0	121.5	1.9	0.7
Blueberry Turnover	60.0	11.0	53.0	124.0	2.0	0.8
Cherry Turonver	62.0	10.0	52.0	124.0	2.0	0.8
Apple Turnover	61.0	9.5	47.0	117.5	1.8	0.7
Pineapple Sticks	62.0	10.0	50.0	122.0	2.0	0.8
Blueberry Sticks	56.0	9.0	41.5	106.5	1.7	0.6
Cherry Sticks	65.0	8.2	49.5	122.7	2.0	0.7
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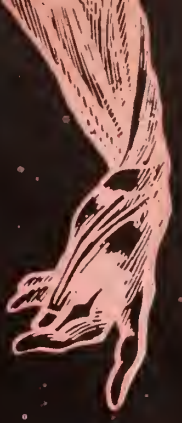
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PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
STUDY 1[1]					
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
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"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

Investigator

after investigator repo

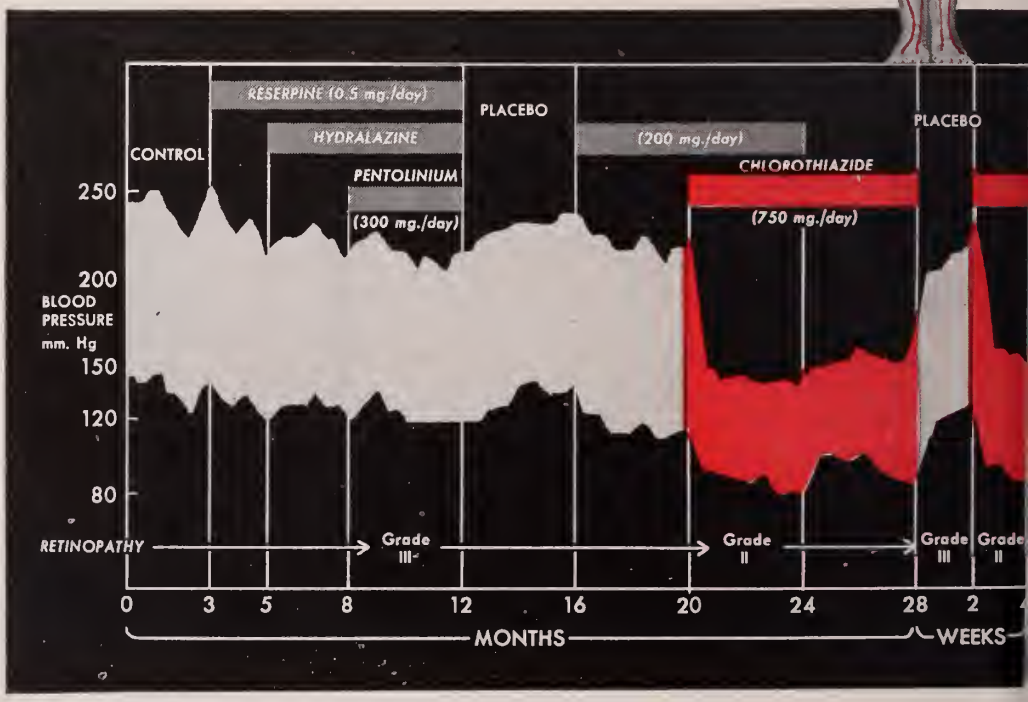
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September 1

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FERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: nt. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. cp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 58. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., mford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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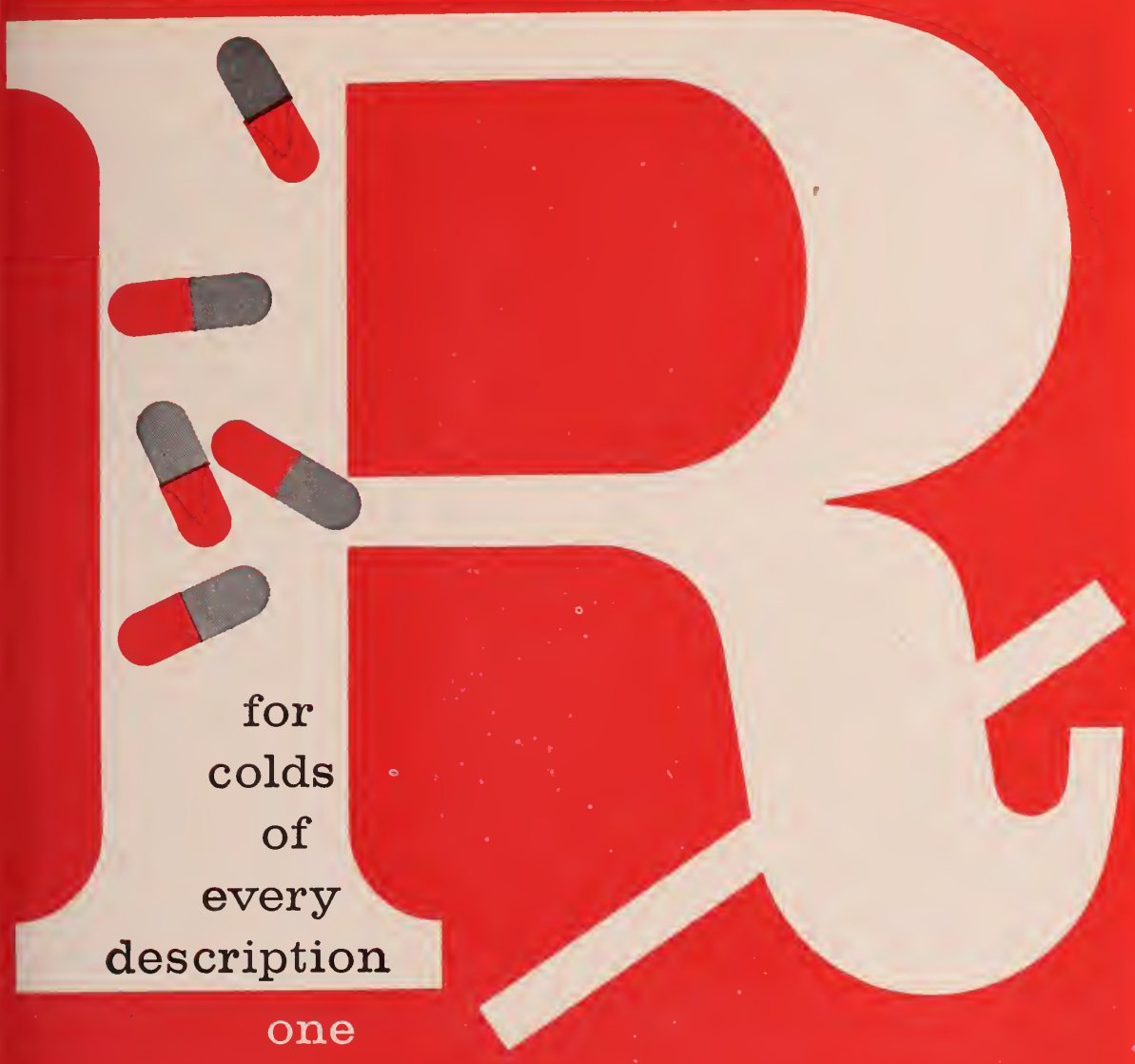
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*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

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THE JOURNAL
OF
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Editorials • • •

The Man Behind the Medicines

Recently there came across our desk a neat brochure called *Career Opportunities in Pharmacy*.* The brochure spotlighted the challenges in pharmacy. And it is good that this is done.

With the advancing front of pharmaceutical therapy, we doctors are becoming more conscious of the man who handles the drugs: the pharmacist. This mid-century is the era of wonder drugs; hormones and antibiotics; isotopes and tranquilizers; steroids and stimulants. From the nadir of nihilism in the 1920s, drug therapy has reached the crest of the cycle. And so there has occurred—or there should occur—a forward shift in the status of the pharmacist.

It is, perhaps, of some semantic significance, that a retail pharmacist is called a "chemist" in countries that fly the British flag, while we generally dub his office a "drug store." It is as if we were emphasizing the merchandising side of his calling, while the British focussed on the scientific aspect. And indeed, it is customary for us to sing a requiem on professional pharmacy, to look back fondly on the good old days when the pharmacist filled his own capsules and made up his own elixirs, tinctures and pills. The implication is that today's pharmacist simply pours medications from big bottles into little ones. But we need waste no regrets. The old-fashioned pharmacist may have been a quaint figure rolling pills and pounding the mortar with his pestle. But he could not possibly have produced finished products of a consistent degree of viscosity, smoothness, weight, acidity, particle size or fineness of suspension. Today's pharmacist may not have to work so hard physically. But he now needs professional skill of a higher order.

Medicine has, of course, made progress in its nonpharmaceutical modalities too. We have better electric shock therapy and psychotherapy for instance; more ingenious surgical opera-

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tions and manipulations; improved environmental control. But most of the dramatic advances have been in the pharmacologic and related therapies. Our most spectacular gains have been in tuberculosis, syphilis, diphtheria, avitaminoses, and the infections. And practically all the progress here has been achieved through the development of better biologicals and pharmaceuticals. It has always been true of our profession that the main business of Medicine is with medicines.

Pharmacy has, let it be remembered, an honorable heritage—one that takes no back seat to any of the other healing arts. As attested by the mention of poultices in the Bible, pharmaceutical formulae on Babylonian tablets and the numerous drug recipes on Egyptian papyrus, the art is as old as civilization. It is one of the earliest efforts of man to control the harshness of nature.

We think of the pharmacist as the man behind the screen of a retail store. And indeed 80 per cent of our pharmacists are so placed. But there are pharmacists in hospitals, in Government service, in teaching, in industry and in research. Indeed, in today's climate—when much of our hope for health lies in pharmaceuticals—there is the potential for exciting and important research in the brain of every pharmacist who has the eye to see it. Even that last sanctum of man, the human mind, is being opened under the hammering impact of a wedge of drugs. Drugs can produce psychoses, and sometimes drugs can heal psychoses. Pharmaceuticals can lull the mind into tranquility or stimulate it into extraordinary energy. Let it be hoped that our fellow-healer, the pharmacist has the initiative, the drive and the imagination to carry into the future his wonderful heritage of the past.

One Big Health Agency?

The dimes march in January; you are asked to have a heart and give to the Heart Fund in February. Crippled Children make an Easter appeal and the American Cancer Society calls to you in April. Mental Hygiene week is in May and the Multiple Sclerosis key signs appear in June. And so it goes through the year—Muscular Dystrophy, Nephrosis, Arthritis, Cerebral Palsy and on to Christmas when the colorful seals of the Tuberculosis Association appear in street booths.

To most medical practitioners, there seems —at first—something wasteful about this confusing grab bag of appeals. It occurs to many that it would be more efficient to unite them into a single voluntary health organization and thus reduce the number of executive secretaries, directors, clerks, and other personnel whose salaries are a first lien on the funds collected. And in a strictly logical sense, this indeed would seem sound.

But the whole operation is emotional rather than logical—and must be seen in that frame. It may make good sense but it doesn't reflect much knowledge of human nature to ask the officials, employees, advisers and boards to surrender their autonomy for the common good. Then too, people want to give to a cause that means something to them emotionally. The parent of a cardiac child is more likely to give generously to the Heart Fund than to an omnibus organization which finances cardiac research as a minor activity. The widower of a woman who died of carcinoma is more likely to donate money to a Cancer Society than to a general health organization. And in a general health organization, there will be constant disagreement over the division of funds. The "one big health agency" idea may be logically sound and may sound logical. But there is something to be said for the apparently inefficient system of a separate organization for each major disease. It fits into the peculiarities of human nature.

Guest Editorial: Verbum Sap

The lady with the lamp, God bless her, sometimes gets cross and tired. To bathe the patient, to change a sheet, to soothe a wrinkle, to give personal service, all seems unglamorous and sometimes unimportant. So now we hear complaints about the alleged coldness or indifference of hospital nurses. A strange complaint about a profession where personal attention is the essence of its mission!

Perhaps the high ratio of married women among our nursing corps is a factor. They must make good wives, and no one would deny to them the bliss of happy marriage. But it is not to be expected that the matron with personal and familial worries of her own, with children to rear and a husband to spoil, can be as dedicated as one to whom nursing was a jealous, solitary life-long career. And in the lifetime of many of us, nursing has been transformed from a 72-hour work week to a 40-hour work-week, from sweat shop wages to respectable salaries, from the social status of skilled craftmanship to that of a learned profession, from the humbleness of the order-taker to the dizzy heights of the leader. We rejoice in this improvement in the status of our oldest aides; but it is not a change which makes people warmer of heart or more concerned with the trivia of daily care.

If the nurse has lost some of her former awe of the doctor, she has developed an effective camaraderie of working relationship. There is greater freedom of exchange now between the two professions. The doctor no longer barks simple orders while the nurse stands up meekly to take them. They can and do talk about the patient, and it is an even exchange of ideas.

This improved level of communication brings with it a danger. If the doctor is critical of the patient, the nurse absorbs the physician's attitude. The doctor may talk sweetly to the patient when he is at the bedside. When the door is closed he may let the nurse know that he really thinks that the patient is a whiner, a complainer, a hypochondriac, a malingerer, or an unreasonable old so-and-so. The nurse takes her cue. The next request for some small service may then be answered in the spirit which the doctor himself had just taught.

There is a dignity about illness, about pain —aye, even about hypochondriasis. The doctor sees the patient's body bared and sometimes his soul bared. Let the practitioner respect this dignity and guard his lips from petty criticism or derogatory remarks. Let him show that he respects the patient with all his faults. The nurse will respond to that cue, too and reflect sympathy and warmth, if the doctor does. The physician who insists on good care for his patients will get it if his manner and actions do not belie his words. And the patient will then praise both the nurse and the doctor. The hospital is a ponderous machine. It will run better for a little oil on the gears.

— Allan J. Ryan, M.D.
Meriden, Conn.

Diamond Jubilee for Doctor Williams

This year marks the 75th birthday for William Carlos Williams, one of the best known and most distinguished members of this Society. It will also mark the publication of his newest book "Paterson Book 5," a final volume in the series which won the National Book Award in 1950. The book is of course named for the industrial city which is the seat of Passaic County in our state. Dr. Williams himself lives in Rutherford.

The Publication Committee joins Dr. Williams' myriad of friends in wishing him another happy birthday. He is truly a wonderful ornament to our profession.

Joseph E. Bossone, M.D.

Long Branch

Physio-Pathology of the Capillaries

In the enchantment of clinical medicine, we often forget our basic anatomy and physiology. The smallest of the vessels, the capillaries, are often overlooked in our interest in arteries and veins. Here, Dr. Bossone focuses on these mighty if microscopic vessels.

The capillaries distributed throughout the entire organism preside over the interchanges between blood, the hormones and tissues. The capillary network may be compared to a large sponge, or to a sieve with very minute perforations. The surface of the capillaries corresponds to eighty square meters which by a happy coincidence, is equal to the alveolar surface of the lungs. The medium length is about 0.5 millimeters. Red blood corpuscles are obliged, due to the very minute caliber of the capillaries, to pass one at a time (Indian file). The velocity is one-half millimeter per second since the red cells number about three million to a cubic millimeter, it will take 5 to 7 hours for the blood to pass the capillary bed. The velocity of the blood stream in the aorta is equal to one-half a meter per second. The velocity in the capillaries is one thousand times less than this; thus, the surface of the capillaries is one thousand times that of the aorta.

There exists a great quantity of capillaries which are not in constant use. These are stand-by vessels, used as they are needed. We thus distinguish the principal, accessory and reserve capillaries.

1. Ebbecke, Karl Joseph: Medisch Weekblad voor Noord Nederland, 17:421 (Aug. 1944).

ANATOMY OF THE CAPILLARIES

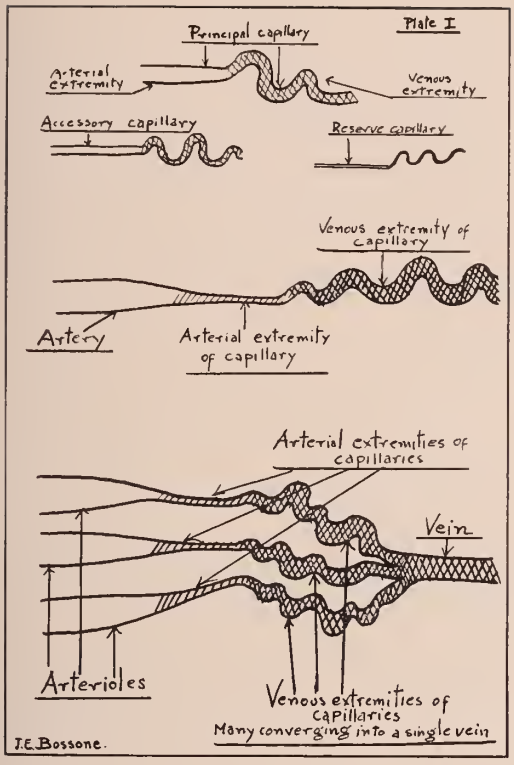
Each capillary has an extremity united with an arterial termination. This is the arterial extremity. It also has an extremity united with a venous termination: the venous extremity. The latter is convoluted and dilated. It is common to see many capillaries each from an arterial extremity, converge into a single vein at the venous extremity.

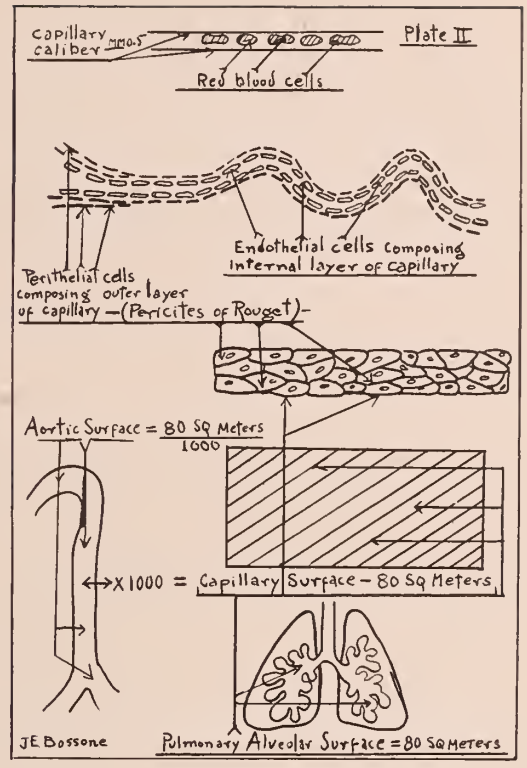
Each capillary is made up of an internal layer of endothelial cells in juxtaposition and an outer layer of perithelial cells (pericites) which are non-differentiated cells of mesenchymal origin. These are more numerous at the arterial and venous extremities and appear to be the continuation of the muscular layer, both of the artery and the vein. These perithelial elements are often called Rouget's Cells. Their importance will be made clear below.

PHYSIO-PATHOLOGY OF THE CAPILLARIES

Ebbecke,[1] has demonstrated that:

(1) The current of the circulating blood in the capillary bed is absolutely independent both of the action of the heart and the tone





of the arteries. If we excise an organ or tie off its vessels, the capillaries still retain their tone. They do not collapse. The discovery of capillary poisons in pharmacology has demonstrated the independence of these elements. As a matter of fact, if the vessels of a limb are tied off, epinephrine still produces capillary ischemia.

(2) The filling up of the capillaries has nothing to do with the sensation of heat. Filling up the capillaries gives a range of color from pink to cyanotic while the sense of heat is produced by the velocity of the blood current in the arteries. Thus, you can have a cold red hand or a warm white hand.

(3) Ebbecke [1] has shown under what conditions the walls of the capillaries may preside over the interchanges between the blood, the hormones and the tissues.

At first, the influence of the neuro-vegetative system was given priority, since an extensive sympathetic-vagal innervation is obvious. Numerous experiments, however, have demonstrated that if such influence exists, it is of secondary importance. Actually, the interchanging currents across the capillary walls are due to products of cellular metabolism of the tissues. This is of chemical origin. Experiments have shown how epinephrine contracts the capillaries and histamine dilates them. Ebbecke [1] isolated a product of cellular metabolism similar to histamine. It is thus shown that histamine is not the only product of cellular metabolism.

Another source of influence on the capillaries has been shown: the electrolytic status of the blood, leading to the perfect counter-balancing harmony of calcium and potassium ions. Epinephrine acts only in the presence of calcium ions, and histamine and insulin in the presence of potassium ions. Thus we can understand how much influence the electrolytic status exercises over the capillary functions.

(4) In their capacity for phagocytosis and fermentation, the endothelial cells of the capillary walls have been individualized almost like leukocytes. Ebbecke [1] compares the endothelial cells of the capillaries to so many little amebae, which have the properties of contraction and versatile movement. Rouget's studies

on the pericites[2] demonstrate the contractibility of these elements which explain the variation in caliber of the capillaries themselves. It also explains the slowing down or acceleration of the force of propulsion in the capillaries. Therefore, truly, as Mueller[3] expresses it, "the capillaries represent an independent apparatus." Recent study of the capillaries has really turned a new light on them. The designation "pluripotent" is really deserved. Histologically, they are a syncytium of mesenchymal cells. They have these characteristics:

(a) Their absolute independence in the power of contraction.
(b) They have a chemical influence which presides over the exchanges that take place across their walls.
(c) They have anti-coagulating power.
(d) They hold back bacteria, reminding us somewhat of the functions of the recticular-endothelial system.

We conclude the physiologic part of the study on capillaries with Mueller's concise quotation,[3] "the capillary bed represents a rigorous and orderly administration of an independent community, and only in morbidity is the intervention of superior offices admissible."

(5) Here are the conditions that may disturb the normal functioning of the capillaries:

(a) Modification in the blood.
(b) In the hormones.
(c) In the tissues.

Experiments have shown, in the individual put on a strict meat diet for two weeks, tracts of deformed capillaries with extravasation. This picture disappears with a strict milk diet. The findings in the capillary bed in diabetes are known: enormous development of the capillaries, histologic alterations of their walls, bloody extravasations.

Also to be considered are conditions of endocrine disturbances and concomitant disturbances in the neuro-vegetative system. This explains what Mueller[3] terms, "angio-neurotic diatheses." It ranges from the mildest form of cyanosis to Raynaud's disease. Some forms of capillary disturbances are attributed to the thyroid and hypophysis. Certain forms of obesity of endogenous origin are explained by these same alterations in the capillary bed.

There also exist poisons peculiarly selective to the capillaries: These include, arsenic, antimony, Alpine lamp effects, irradiation by ultraviolet rays, and roentgen rays. Capillaryoscopy if used in time would enable us to diagnose radio-dermatitis before it becomes evident clinically.

Mueller and his co-workers[3] have shown the existence of what they call an "atonic state of the venous portion." This leads to a localized or generalized "passive stasis." Passive stasis, in turn, may lead to functional as well as anatomic alterations. For instance, it has been demonstrated gastroscopically that certain peptic ulcers can be produced by atonic spastic dysergias.

Affections of the capillaries are grouped into those of endogenous and those of exogenous origin. In the *endogenous group*, we include localized and generalized forms. The localized forms embrace the angioneuroses ranging from the simple to the complex, with Raynaud's disease at the end of the spectrum. In this group are a variety of the forms of dermographia.

In the generalized group, we include "red hypertension" or *rubra*. This occurs when the arterial extremity of the capillaries is spastic while the venous extremity is dilated. Remember that this can involve a capillary surface of 80 square meters—and thus it can determine a truly extensive hypertension. The effect on nutrition of the organism can also be imagined.

In *exogenous* affections, we recognized both localized and generalized forms. We recognize four varieties of local atonic-spastic capillary disorders:

(a) Traumatic swelling or edema.
(b) Swelling following subcutaneous injection of peptones.
(c) Histamine-produced local edema.
(d) Allergic or anaphylactic edema.

In the more generalized category, we recognize many bacterial toxins which can determine a generalized atonic spastic dysergia dur-

2. Rouget, Antoine Danat: Memoires de la Faculte de medicine de Paris, 44:1492 (January 1876).
3. Mueller, Friedrich V.: Zeitschrift fur Heilkunde, 16:8 (March 1912).

ing the course of various infectious diseases. In these we are able to show a small hypotensive pulse with the tendency of the heart to stop in diastole. This is due precisely to atonic spastic dysergia of the capillaries, which for extraordinary distension of the venous tract, determines a generalized passive stasis. It is obvious how important it is to help the heart in the infectious diseases, giving it "tone" until it overcomes the peripheric barrier. This is one reason for sudden death in acute diseases.

Atonic spastic dysergia also explains the mechanism by which during infectious disease we have an increase in the volume of the liver (infectious liver). Atonic spastic dysergia of the capillary bed accounts for the increased volume of the liver.

255 Third Avenue

The Food Supplement Racket

Americans have to go out of their way to avoid being well nourished. That's how it is expressed in the September 1958 issue of *Today's Health*. Salesmen in the "food supplement" business are trying to convince people that improper diet is to blame for most disease and that it can be cured by taking food supplements.

The food supplement business is a multimillion dollar one. It could be considered a "mildly amusing confidence game" except that it is also highly dangerous. Persons with serious ailments neglect proper medical treatment in the hope that they can find a cure in a capsule.

Food supplements often contain vitamins and minerals in amounts greater than the body needs and some "mysterious ingredient" that is usually nothing more than a dehydrated vegetable and plants.

The most popular pitches used by the self-styled "nutritional advisers" in selling their supplements are outlined by Joseph N. Bell in the *Today's Health* article. It is part of a campaign being conducted by the A.M.A., the Food and Drug Administration, and the National Better Business Bureau to combat food faddism.

The pitches are:

—Most disease is due to improper diet. *The fact*: There are a few diseases caused by dietary deficiencies, but they are rarely found in the United States. By patronizing all departments of a grocery store, a person can easily supply all of his nutritional needs.

—Soil depletion causes malnutrition. *The fact*: The composition of the soil has little effect on the composition of plants grown on it. If soil elements are missing, the plants simply don't grow.

—Chemical fertilizers poison the land and the crops grown on it. *The fact*: The nutritional value of crops is not significantly affected by the soil or the fertilizers used.

—Wonder power of wonder foods, such as 100 per cent whole grains—cereals, flours, bread and crackers; honey; maple syrup; blackstrap molasses, or raw vegetables. *The fact*: These are not wonder foods and do not supply any miracle nutrients.

—Certain types of cooking utensils, especially aluminum, are harmful to foods. *The fact*: Hospitals use aluminum cooking utensils. They certainly would not if research had given the slightest suspicion of danger from it.

—Processing removes nutritional values from food. *The fact*: Modern processed foods contain more nutrients than the same foods prepared by home cooking. Fruits and vegetables are canned or frozen at the peak of nutritional perfection, and flour, bread, milk and margarine are all improved in processing to supply known dietary requirements.

John W. Frost, M.D.

Philadelphia, Pennsylvania

Coagulation Factors Relating to Obstetrics and Gynecology*

Not all gynecologic and obstetrical bleeding is due to poor surgical technic, uterine atony or other "mechanical" causes. Sometimes defects in blood coagulation are responsible. In this compact monograph, Dr. Frost gives us a run-down on this problem.

Most hemorrhagic phenomena in obstetrical and gynecologic patients are due to mechanical causes, such as uterine atony and failure to secure adequate hemastasis at the time of surgery. However, disorders of blood coagulation are also operative in certain patients. The patients with disordered coagulation mechanism can usually be adequately controlled if the disorder is recognized and prompt definitive therapy instituted.

The mechanism of blood coagulation is a complicated and poorly understood process. Part of the confusion stems from terminology and from the difficulty in delineation of specific factors by the methods at hand for their detection. The end point of all tests for coagulation factors is the clot. Since the time consumed for its formation is of utmost importance, the human "opinion" factor is of prime importance in performing the tests. In any coagulation laboratory there are often differences of opinion as to just when one should call a mass of congealed blood a clot!

Clotting is induced by the conversion of a soluble protein, fibrinogen, into an insoluble protein, fibrin. The process results from the action of an enzyme thrombin which is thought to be proteolytic.

Thrombin presumably does not exist as such in any appreciable amount in normal circulating blood, but is present as a precursor, prothrombin. By what means is the prothrombin of the circulating blood changed to thrombin when the blood is shed? This simple query is one of the most controversial questions in hematology. The change is thought to take place through the action of the group of substances that generically may be called thromboplastin. Thromboplastin is found in animal tissues including the placenta and in amniotic fluid. Thromboplastic properties also appear in shed blood uncontaminated with other tissues. The blood platelets play their part by disrupting early in the clotting process liberating a substance which reacts with plasma factors to give rise to thromboplastin. There is evidence, however, that when blood comes in contact with a wettable surface, thromboplastic activity appears in the plasma itself independent of any cellular elements. A number of factors such as, antihemophilic factor (or thromboplastinogen), plasma thromboplastin component (or Christmas factor), and

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plasma thromboplastin antecedent, may contribute to the thromboplastin activity of the serum. Calcium ions are required for the conversion of prothrombin to thrombin. The process is accelerated by at least two other factors: accelerin (serum accelerator globulin, Factor V) and convertin (serum prothrombin conversion accelerator, Factor VII).

At the risk of over-simplification, one should consider clotting as occurring in three stages.

Stage I: The formation of thromboplastin
Stage II: The formation of thrombin
Stage III: The conversion of fibrinogen to fibrin

STAGE I OF BLOOD COAGULATION

IN STAGE I of the coagulation process (the formation of thromboplastin) a number of factors are operative and may be grouped together and referred to as thromboplastin or thromboplastic substance. These substances include a number of protein materials that are associated with the globulins of the plasma. All these substances are concerned with the formation of thromboplastin. The physical-chemical properties of these substances are important. Replacement therapy is dependent upon the selection of the proper type of blood or plasma for correction of any known defect. The properties of the thromboplastic substances along with the type of replacement necessary and the tests used for their detection are listed in Figure 1.

Platelets are apparently necessary for the optimal conversion of prothrombin to thrombin in ordinary clotting. They are likewise needed for rapid development of plasma thromboplastic activity. They are essential for clot retraction and appear to possess vasoconstrictor activity (seratonin). The nature of the surface with which the blood comes in contact is important in determining the rapidity with which it will clot. Non-wettable surfaces such as petrolatum and silicone delay the clotting process, whereas glass and metallic surfaces accelerate it presumably due to breakdown of the blood platelets. Adequate appraisal of the number of blood platelets is made from careful inspection of a well stained and well made blood smear. Blood platelets are extremely labile and methods for the replacement of platelets are poor. Recently blood collection and separation in silicone equipment have resulted in a preparation of platelets that will give temporary effect to patients who lack platelets or are bleeding because of their lack.

AHG (*Antihemophilic globulin*) is an euglobulin present in normal plasma. It is the substance that is lacking in true hemophilia. This form of hemophilia is a hereditary disorder inherited as a sex link recessive, and is present only in males. Lack of antihemophilic globulin will cause a marked prolongation of the clotting time which is inversely proportional to the amount of the substance present in the plasma. This factor is labile and may be largely inactivated even at refrigerator temperature in 24 hours. Its replacement, therefore, depends upon the use of fresh blood or fresh frozen plasma. Lyophilized plasma is not satisfactory for replacement of the antihemophilic factor since it is usually manufactured from plasma obtained from outdated blood.

FIGURE 1.

STAGE I
THE FORMATION OF THROMBOPLASTIN

Factors	Tests	Stability	Replacement
Platelets	Blood Smear Platelet Count	Labile	Poor (Plat. Trans.)
AHG	Clotting Time	Labile	Fr. Frozen Plasma Fresh Blood
PTC	Recal. Time	Stable	Plasma; Serum
PTA	Proth. Consump.	Stable	Plasma; Serum

Fresh frozen plasma may be prepared by removing plasma from freshly drawn blood and immediately storing it in a deepfreeze at minus 20 Centigrade.

PTC (Plasma Thromboplastin Component Factor) is found in normal plasma in association with the beta[2] globulin fraction of plasma and serum. The factor is stable and appears to be dependent on adequate levels of Vitamin K for its formation. Because of the stability of PTC, replacement can be made by the use of stored or lyophilized plasma or serum. The clinical condition caused by the lack of this factor is known as hemophilia B or Christmas disease. This accounts for about 15 per cent of patients previously considered to have true hemophilia. The lack of the substance is inherited as a sex link recessive that has varying degrees of severity. The defect is easily corrected by the above described manner.

PTA (Plasma Thromboplastin Antecedent Factor) is likewise found in the beta[2] globulin and is essential for plasma thromboplastin formation. It is a stable substance present in both normal plasma and serum. One tests for its presence by performing a prothrombin consumption test. Because of the stability of PTA, replacement is made by using stored or lyophilized plasma or serum. Lack of plasma thromboplastin antecedent factor is an inherited abnormality although isolated cases of its occurrence are known. It affects males and females and is transmitted as a dominant with incomplete penetrance and no sex linkage.

STAGE II OF BLOOD COAGULATION

THE second stage of blood coagulation involves the conversion of prothrombin to thrombin. This stage requires three factors essential for the formation of thrombin under the influence of thromboplastin and calcium, as represented in Figure 2.

Prothrombin is a stable glycoprotein. It is found in normal plasma but is rapidly consumed in the clotting of normal blood so that only traces are found in serum. Prothrombin is presumably formed in the liver which requires Vitamin K for an enzymatic step involved in its formation. Liver synthesis of prothrombin can be inhibited by certain coumarin drugs having a structural resemblance to Vitamin K. It is thought that this inhibition of synthesis is the result of competitive interference and that naturally occurring Vitamin K deficiency is identical with that induced by coumarin drugs. Normal plasma contains excessive amounts of prothrombin since bleeding does not occur in patients receiving coumarin drugs unless the prothrombin level has been decreased to less than 20 per cent of normal. Deficiencies of prothrombin and other factors operative in the second stage of blood coagulation may be found in liver disease, and in any patients known to have liver disease. It is imperative that a prothrombin time determination, which will detect absence of these factors, should be performed prior to any surgical procedure. Therapy in this group of patients consists of measures

FIGURE 2.

STAGE II

CONVERSION OF PROTHROMBIN TO THROMBIN

Factors	Test	Stability	Replacement
Prothrombin	Prothrombin Time	Stable	*Vit. K or K_1 Banked Blood Banked Plasma
AcG (Factor V)	Prothrombin Time	Labile	Fr. Frozen Plasma Fr. Blood
Factor VII (SPCA)	Prothrombin Time	Stable	Banked Blood Banked Plasma *Vit. K or K_1

*Only if Vit. K Deficiency

to improve liver function, replacement of the factor if hemorrhagic episodes occur, preferably with fresh blood, and the administration of Vitamin K especially in cases associated with obstructive jaundice. Deficiencies of prothrombin complex are but a small part of the hemostatic defect of liver disease. Fibrinogen deficiency, fibrinolysin, and vascular factors are of importance and must be evaluated.

Deficiencies of Vitamin K and hence hypoprothrombinemia are found in various other diseases not associated with primary hepatic disease. Since naturally occurring Vitamin K is fat soluble, deficiency is found in steatorrheas and biliary obstruction or fistula. Various diarrheal states, and defective elaboration of Vitamin K by intestinal bacteria (whether induced by antibiotic administration, or naturally occurring neonatally) are other causes of deficiency. Neonatal hypoprothrombinemia is the most probable cause of hemorrhagic disease of the newborn. The administration of Vitamin K prophylactically to the mother prior to delivery or to the child following delivery will prevent the expected fall of the prothrombin although it does not restore levels to normal. Iatrogenic hypoprothrombinemia caused by the administration of coumarin drugs is a true induced Vitamin K deficiency, and may be encountered in patients undergoing emergency surgery.

The therapeutic use of Vitamin K is complicated by the multitude of preparations. Synthetic vitamins are water soluble and naturally occurring vitamins are fat soluble. If a water soluble preparation does not appear to be effective, a potent fat soluble preparation should be used. Hypoprothrombinemia due to severe liver disease or on a congenital basis does not respond to either type of Vitamin K preparation. However, Vitamin K is recommended in all cases of hypoprothrombinemia since the exact basis for the deficiency may not be immediately known. A response to the administration of Vitamin K constitutes in itself a valuable clue as to the cause of the prothrombin lack. Fat soluble Vitamin K cannot be absorbed when administered orally in the presence of obstructive jaundice or biliary fistula unless given with bile salts. The synthetic water soluble Vitamin K preparations are slow acting in the therapy of hypoprothrombinemia associated with coumarin toxicity. The fat soluble Vitamin K_1 emulsion preparation should be used intravenously if active bleeding is occurring, and intravenously or orally if the problem is merely an excessively prolonged prothrombin time. In doses of 50 to 150 milligrams of Vitamin K_1 emulsion the prothrombin time will be in a safe range in three hours, but because of the prolongation of coumarin effect, Vitamin K_1 therapy should be continued for several days. The emulsion is supplied in a concentration of 50 milligrams per cubic centimeter, and should be diluted with sterile water or isotonic saline so that a final concentration of 10 milligrams per cubic centimeter is obtained. Because of the lag phase in prothrombin formation following the administration of all types of Vitamin K preparations their administration should always be supplemented in dangerously bleeding patients by transfusions of bank blood or bank plasma.

AcG (*Accelerator globulin, Factor V, accelerin, labile factor*) is a labile factor found in normal plasma that is essential for thrombin formation in the second stage of blood coagulation. It is thermo-labile and disappears from aging plasma and blood. Vitamin K is not required for its production nor is it influenced by the coumarin drugs. The critical level of the labile factor is about 20 per cent of the normal. Since this factor disappears rapidly from banked blood or plasma its replacement is dependent upon the use of fresh frozen plasma or fresh blood.

Factor VII (*Stable factor, SPCA, Proconvertin*) is an extremely stable factor found in normal plasma. It is in a more active form in serum and apparently increased with aging of blood. The coumarin drugs reduce its concentration rapidly and perhaps to a greater extent than prothrombin. Its dependence on Vitamin K implies a mode of formation closely related to that of prothrombin. Because of the stability of factor VII it may be replaced by administering bank blood, lyo-

philized plasma or serum. Because of its dependency on Vitamin K for its formation by the liver, this vitamin should be administered in cases known to have a deficiency of factor VII.

The absence of all three factors (prothrombin, AcG, and Factor VII) necessary for the second stage of blood coagulation can be determined from the prothrombin time. In the performance of a prothrombin time all the material necessary for the first stage of coagulation are added to the test plasma. Therefore, a normal prothrombin time means that there are adequate amounts of the second and third stage factors present, *i.e.*, Prothrombin, AcG, Factor VII, and fibrinogen. An abnormal prothrombin time means that one or more of the factors are present in decreased amounts.

Many laboratories report prothrombin times in seconds which is of little value unless the physician is aware of the prothrombin time of normal plasma on the day the test is made. It is of more clinical value to report prothrombin times in per cent of normal rather than in actual seconds required for the clot to form in the test system.

STAGE III OF BLOOD COAGULATION

THE third stage of blood coagulation as shown in Figure 3 involves the conversion of fibrinogen to fibrin through the reaction of the enzyme thrombin formed during the first two stages of coagulation. The conversion is accelerated by the presence of calcium ions in the concentration present in the shed blood.

Fibrinogen is a protein present in plasma in a concentration of 250 to 400 milligrams per 100 milliliters and has a molecular weight of 350,000. The protein is rich in glutamic and aspartic acid and contains some carbohydrate. The material is stable on storage and is found in normal plasma. The critical level of fibrinogen is thought to be 60.* However, bleeding has been observed at levels of 100;* therefore, 100* should be considered to be the critical level.

Fibrinogen may be determined chemically but the procedure is time consuming and not available for the rapid determinations of fibrinogen content in conditions where adequate replacement is necessary and promptness mandatory. In cases where prothrombin is present in adequate amounts, the prothrombin time is a readily available method of determining fibrinogen. Another popular method known as the "Fibrindex" involves the addition of a known amount of thrombin to the plasma and determining the fibrinogen indirectly by allowing the clot to form. The procedure is standardized so that a given amount of plasma will clot on the addition of the thrombin. The test will indicate only that the concentration of fibrinogen in the patient's plasma is greater than 60.*

Fibrinolysins are proteolytic enzymes derived from tissues and formed by the action of the leucocytes. There is evidence that the blood itself contains a fibrinolytic enzyme called plasmin that is carried in the globulin fraction of the plasma and exists mainly in a precursor form known as plasminogen. This substance acts to dissolve normal clots in certain conditions, namely, liver disease, toxemia of pregnancy, carcinoma of the pancreas, car-

*Milligrams per 100 milliliters.

FIGURE 3.

STAGE III

CONVERSION OF FIBRINOGEN TO FIBRIN

Factors	Test	Stability	Replacement
Fibrinogen	Prothrombin Time	Stable	Conc. Fibrinogen
	'Fibrindex' Clotting Time		
Fibrinolysins	Lysis of Clot	....	Conc. Fibrinogen

cinoma of the prostate, carcinoma of the stomach, and in shock. The presence of fibrinolysin can be readily detected by observing the breakdown of a normal clot which will liquefy on standing.

APPLICATION TO GYNECOLOGY AND OBSTETRICS

From these considerations it can be seen that gynecologic surgeons may encounter patients who lack any of the above factors necessary in the various stages of coagulation. Fortunately, these patients are usually detected prior to surgery and proper pre-operative preparation with replacement therapy as outlined above can be provided and hemorrhages at the operating table and in the postoperative period prevented. The problem is different in obstetrical patients since hemorrhagic states may present themselves, at the time of delivery or shortly thereafter, in patients who in the past have had normal coagulation mechanisms. The hemorrhagic states associated with pregnancy are fortunately transitory. Abnormalities occur near parturition, but may be responsible for uterine or even generalized bleeding. These syndromes include hemorrhagic phenomena associated with premature separation of the placenta, amniotic fluid emboli, the presence of a dead fetus and eclampsia or severe pre-eclampsia. Generalized bleeding tendency may also occur early in pregnancy as the sequelae to criminal abortion.

The clotting mechanism is normal during a normal pregnancy. Studies of all phases of blood coagulation throughout pregnancy have demonstrated that there is no decrease in any of the factors associated with the various stages of coagulation throughout the entire term of the pregnancy. Few alterations in clotting mechanism have been detected during the course of normal labor, and in the immediate normal postpartum period. The clotting time, the concentration of prothrombin, and the thrombin time remain unchanged. There may be slight or inconsistent changes in the concentration of fibrinogen and platelets. After delivery there is an increase in the plasma fibrinolytic activity. The time that elapses until clotted plasma dissolves shortens from three or more days antepartum to a minimum of less than 24 hours, two to four hours postpartum. At the end of 48 hours postpartum, however, clot lysis has usually returned to normal. The cause or significance of this rapid fibrinolysis is not known. Rapid lysis does not appear to result from a decrease in the inhibitory activity of the plasma against plasmin or from a change in the amount available fibrinogen or other factors of coagulation.

Most obstetricians know that blood expelled from the uterus after separation of the placenta is usually incoagulable. This blood does not clot when thrombin is added which would indicate it is devoid of fibrinogen. The addition of fibrinogen alone, however, does not result in clotting and both fibrinogen and thromboplastin have to be added to postpartum uterine blood to induce coagulation. Once the blood has clotted by the addition of fibrinogen and thromboplastin the clot does not undergo lysis which would indicate that a fibrinolysin is not present. On the basis of these findings it is thought that the early control of postpartum uterine bleeding is effected primarily by adequate uterine contraction. It has been suggested that the incoagulability of uterine blood following placental delivery may be due to the formation of clots within uterine vessels at the placental site, and therefore, the incoagulable uterine blood would then actually be a mixture of extruded cells and serum.

HYPOFIBRINOGENEMIA AND AFIBRINOGENEMIA

Afibrinogenemia and hypofibrinogenemia occurring during pregnancy are associated with certain cases of premature separation of the placenta, amniotic fluid emboli or intrauterine retention of a dead fetus. The exact mechanism by which the decrease in fibrinogen occurs is not entirely understood, but it is concluded by most investigators that the intravascular defibrinogenation of the maternal blood occurs as the result of release of thromboplastic material (such as amniotic fluid) into the maternal circulation with re-

sultant coagulation of fibrinogen within the maternal blood vessels. Experiments on animals done as early as 1886 showed that the slow intravenous infusion of tissue thromboplastin rendered blood incoagulable, and that this was accompanied by a decrease in the concentration of fibrinogen in the circulating blood. This decrease in fibrinogen was shown by other investigators to be the result of vascular clotting and microscopic thrombi have been demonstrated in the small blood vessels of animals suffering from afibrinogenemia as the result of thromboplastin infusion. In many of the studies of afibrinogenemia that have been performed on experimental animals it is interesting to note that in some, placental tissues and amniotic fluid have been used as the source of thromboplastic material.

In obstetrics, the detection of hypofibrinogenemia as soon as possible is of utmost importance. Sufficient time is usually not available for a chemical determination of the exact concentration of fibrinogen in the patient's blood. Despite a number of reports to the contrary, the clotting time of whole blood is of little or no value except when the blood is completely incoagulable. Clotting time may be prolonged despite the presence of normal amounts of fibrinogen, and may be normal even though there is hypofibrinogenemia. However, the gross appearance of the patient's clotted venous blood (not placental blood) may be of some help.

EVERY operating and delivery room should be provided with equipment suitable for a simple test for hypofibrinogenemia. The material needed consists of scrupulously clean Pyrex glass test-tubes and a solution of topical thrombin such as is found in most surgical and emergency wards. The tubes are prepared by adding 0.1 cubic centimeters of the topical thrombin solution and stored in the deepfreeze. Other glass tubes containing 0.5 cubic centimeters of Sodium or Potassium Oxalate should also be on hand.

Ten cubic centimeters of venous blood are drawn immediately through an 18 gauge needle. The needle should be removed from the syringe and a tube containing the thrombin material should be filled to the 1 cubic centimeter mark. Five cubic centimeters of the drawn blood should be added to the oxylate tube and mixed thoroughly. This blood can be used later to perform prothrombin time, "Fibrindex" chemical fibrinogen determination, and other studies. Three cubic centimeters should be added to an empty Pyrex tube of similar diameter to the one containing the thrombin solution.

Failure of the blood to clot in the tube containing thrombin is indicative of afibrinogenemia. If hypofibrinogenemia is present a clot may form that is either small in appearance or shrivels in a minute to a small size either spontaneously or upon gentle tapping of the tube. A firm clot of good size suggests that a normal amount of fibrinogen is present in the tube. This test gives an almost immediate answer since clotting of a mixture of normal blood and the amount of thrombin in the Pyrex tube requires only a few seconds. Afibrinogenemia will also be indicated by the failure of the 3 cubic centimeters of blood in the plain Pyrex tube to clot. If the clotting in both the thrombin and the plain glass tube takes place, the clot should be observed at frequent intervals for fragmentation or lysis. In normal individuals two days or more are required for the lysis of a normal clot. Much more rapid clot lysis occurs in patients with hypofibrinogenemia or fibrinolysins. It is likely that fibrinolysins are of clinical significance in hemorrhagic states only when the clot lysis time is a matter of less than 1 to 2 hours.

Once the diagnosis of hemorrhage due to hypo or afibrinogenemia is made, prompt treatment is of utmost importance. Four grams of a purified human fibrinogen should be immediately given intravenously. If fibrinogen is not available repeated blood transfusions will be needed to raise the concentration of fibrinogen in the patient's plasma. On an average, 500 cubic centimeters of blood contains 1.5 Grams of fibrinogen. After injection of the fibrinogen solution the test for fibrinogen should then be repeated and more fibrinogen or whole blood given as indicated, by the results of these tests. Cases have been reported in which as much as 16 Grams of fibrinogen and the transfusion of 11 units of blood were required to correct the afibrinogenemia. The

treatment of fibrinolysins is the same as for hypo or afibrinogenemia. The problem is that of supplying enough fibrinogen to exhaust the supply of fibrinolysin until the obstetrical cause which produced the lysin is corrected. Patients with fibrinolysin will often require massive amounts of fibrinogen until the effect can be corrected.

TOXEMIA OF PREGNANCY

Although pre-eclampsia and eclampsia are not ordinarily thought of as being associated with hemorrhage defects, cutaneous hemorrhages are not unusual in this disorder, and bleeding into the central nervous system is a frequent terminal event. In one series, hemostatic defects were observed in 29 out of 31 patients having eclampsia or pre-eclampsia. The most frequent change has been a prolongation of the clotting time of a mixture of plasma and bovine thrombin. Other abnormalities such as thrombocytopenia with platelet counts in a level below 100,000 platelets per cubic millimeter have been observed. Hemoglobulinuria and hemoglobinemia have also been found. The pathogenesis of the hemorrhagic phenomenon of pre-eclampsia and eclampsia is not entirely known. The possibility of some aberrant immunologic mechanism has been suggested but has not been proved. The therapy of the hemorrhagic phenomenon associated with toxemia is unsatisfactory, although adrenocortical steroids and ACTH have been of benefit in some cases.

CIRCULATING ANTICOAGULANTS

Patients with hemorrhagic phenomena during pregnancy associated with circulating anticoagulants have been reported. The clinical picture is similar to that of hemophilia. Bleeding may occur in the joints, soft tissue and skin. There may be hematuria. The clotting time of venous blood is greatly prolonged despite a normal thrombin and prothrombin time which would indicate that the defect is in the first stage of blood coagulation. A small amount of the patient's blood greatly prolongs the clotting time of normal blood. This suggests the presence of a circulating anticoagulant. Because of the presence of an anticoagulant, transfusion of normal blood will not correct the patient's coagulation defect although this procedure may be needed to treat shock and to replace lost blood. The pathogenesis of this mechanism is entirely unknown and the circulating anticoagulants may be detected for several years following pregnancy.

THROMBOCYTOPENIC PURPURA IN PREGNANCY

Pregnancy is occasionally complicated by thrombocytopenic purpurae. In some patients the decreased number of platelets is the result of idiopathic thrombocytopenic purpura of the mother, or sensitivity to drugs such as quinine or quinidine. In mothers with thrombocytopenic purpura the treatment should not differ in pregnant and non-pregnant patients. Current thinking regarding the treatment of idiopathic thrombocytopenia involves the use of adrenocortical steroids which are effective in controlling the thrombocytopenia in most patients with the disease, thus eliminating the need for splenectomy during the pregnant period.

STATES ASSOCIATED WITH BLOOD TRANSFUSION

Surgical patients who require massive blood replacement (whether due to bleeding or prolonged operations with shock) may develop a hemorrhagic phenomenon. One of the chief causes of such hemorrhagic diathesis is the decrease in concentration of the factors necessary for blood coagulation by the introduction of large amounts of whole banked blood deficient in these factors. The labile factors in whole blood (platelets, antihemophilic globulin, and accelerator globulin) disappear from banked blood promptly on storage. Present methods of blood preservation are designed to maintain the red blood cells for periods as long as 21 days. However, the above men-

tioned blood coagulation factors disappear swiftly from bank blood. A state of deficiency results when large amounts of bank blood are transfused into the surgical patient.

The exact cause for the thrombocytopenia developing in patients who receive massive blood transfusions is unknown. It may be related to an immunologic mechanism whereby normal circulating platelets of the recipent are agglutinated and perhaps destroyed by antibodies in the donor blood. The labile factors in the recipient are diluted to what may be a hemorrhagic level. It should be the common practice to administer one unit of fresh frozen plasma to supply the necessary labile factors (except platelets) for each 4 units of bank blood which is administered to a surgical patient. By this method, the doctor can prevent a hemorrhagic diathesis due to dilution of normal factors in the recipient.

TESTING FOR THE DEFECT

THE study of a coagulation defect or a suspected coagulation defect in an obstetrical or gynecologic patient does not require a battery of complicated and highly technical tests to ascertain the defect and institute proper treatment. As outlined in Figure 4, six simple tests, which can be performed in most hospitals and in fact in some physicians' offices, will rule out most major coagulation defects. These tests can be done inexpensively with a minimal loss of time. Adequate therapy can then be instituted promptly. By doing a simple clotting time and observing the clot for retraction and lysis of the clot, hemophilia, afibrinogenemia, thrombocytopenia, and fibrinolysis can be detected. A well done platelet count or an inspection of a well made blood smear by a competent observer can adequately rule out thrombocytopenia as the cause of a bleeding state. A prothrombin time determination if normal would rule out a second or third stage defect of coagulation. The simple "Fibrindex" determination will tell the physician if the fibrinogen level is below 60.*

FIGURE 4.

ROUTINE COAGULOGRAM

(If all normal look for a bleeding vessel!)

Test	Rules Out (if normal)
1. Clotting Time	Hemophilia, Afibrinogenemia
Clot Retraction	Thrombocytopenia
Lysis of Clot	Fibrinolysins
2. Platelet Count (Smear Inspection)	Thrombocytopenia
3. Prothrombin Time	Stage II or Stage III Defect
4. 'Fibrindex'	Fibrinogen below 60 mgm.

Most blood coagulation defects can be corrected by the prompt administration of fresh whole blood. Bank blood is ineffective in correcting some of the more important blood coagulation defects such as AHG hemophilia, and defects involving lack of the labile factor in the second stage of blood coagulation. Fresh frozen plasma is easily prepared and should be available in every hospital in which major surgery is attempted, and blood replacement with large amounts of whole blood is anticipated. Purified fibrinogen is obtained from the American Red Cross and should be available for the coagulation defects due to afibrinogenemia. A preparation of Vitamin K should be administered to all patients with bleeding diathesis since it constitutes a very valuable therapeutic test for prothrombin and Factor VII deficiencies.

I have stressed the importance of factors in blood coagulation responsible for bleeding in obstetrical and gynecologic patients. However, it must be emphasized that in most of these patients bleeding is due to mechanical causes, and poor surgical technic, rather than due to coagulation defects.

*Milligrams per 100 milliliters.

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Bibliography will appear in author's reprints.

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Orange

Atopic Dermatitis*

Dr. Bensel here suggests a four-fold approach to atopic dermatitis: general medical management, the allergic approach, dermatologic treatment, and emotional support. Each technic is briefly reviewed.

Within the concept of atopic dermatitis are included flexural eczema, infantile eczema and neurodermatitis. This discussion will not cover the diseases in the allergic-eczematous-contact group.

The literature abounds with articles about atopic dermatitis which generally deal with a special approach to the topic with which the author has had particular success. However, no one approach is uniformly successful in atopic dermatitis. Atopic dermatitis is generally a chronic, recurrent and benign disease. However, extreme forms of the disease are as severe and disabling as advanced rheumatoid arthritis. Generalized exfoliative dermatitis with electrolyte imbalance and protein depletion is an ominous and serious situation, particularly in infants where deaths from this complication are not uncommon. Cataracts are found in as many as 7 per cent of persons with chronic exfoliative cutaneous disease. The amount of subjective discomfort is difficult to estimate but is surely very great. A rational management is helpful but difficult for the patient to understand and accept.

Following is an outline of a plan that I have found effective in the Skin Allergy Department of the Vanderbilt Clinic in New York City. The general approach is fourfold:

1. General medical management.
2. The allergic approach.
3. The dermatologic approach.
4. The psychologic approach.

General Medical Management

A meticulous medical evaluation of every patient with atopic dermatitis should be made on the first visit. A physical examination, including routine laboratory work, is done at this time. Foci of infection, blood dyscrasias or other systemic disease can aggravate atopic dermatitis. And, as with any persistent erythroderma, the possibility of a lymphoma must be considered. Correction of underlying systemic disease where practicable often helps to alleviate a stubborn case of atopic dermatitis.

The Allergic Approach

The search for causative allergens, elimination diets, the withdrawal of substances from the environment, and attempts at desensitization still persist. I feel it is advisable to do scratch tests for the common allergens and to try to eliminate the external offenders. However, false hope should not be built up in the patient or his family. Too often withdrawal of substances from the diet or environment lead to a spurious sense of security on the part of the patient. They then get the impression that the cause of their trouble is the offending substance rather than the innate sensitivity with which they were born. I routinely do scratch tests with such items as certain foods, animal danders, feathers, house dust and so on. These are done to determine the pa-

*Read before the Section on Allergy, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 21, 1958.

tient's index of reactivity as a whole rather than to find any specific causative agent. Interpretation of large numbers of these scratch tests leads me to the conclusion that most patients react to many foreign proteins introduced into the skin rather than show selective reactions to certain substances. I am sure that there are some who will contradict me on this, but I am referring to most patients and not the unusual idiosyncrasy.

How much emphasis should be placed upon the allergic approach? There are many fascinating phenomena which can be demonstrated in the laboratory. However, I will not go into detail about the experimental reactivity of tissues. Rather, let me state simply, that the classical allergic phenomena are concerned with alterations produced in an animal when large molecular weight foreign protein structures called *antigens* are introduced. These alterations consist in production of another large molecular weight protein called an *antibody*. Antibodies are demonstrated in the blood only after a delay period. The origin and method of production of this antibody are obscure, but there is evidence that the lymphocyte or reticuloendothelial cell may elaborate it. This antibody protein is unique because of its great specificity for combining with the antigen protein which stimulated its production. The specific combination of antigen and antibody is believed to be due to structural positioning of various polar groups on the two proteins resulting in strong attraction.

These alterations in the cell do not have to form an antibody. The cell can be altered structurally, biochemically or physiologically. Further, the alteration may be passed on from one generation of epidermal cells to the next. This brings up the question of mutations or permanent alterations of cells with the production of plasmogenes to result in the production of globulin antibodies. This discussion is intended to place the proper emphasis on the fact that, in the classic allergic concepts (where circulating antibodies are involved) the tissue which forms the antibody is the one that is permanently altered or made allergic. The reaction of antigen on fixed antibody to produce histamine-like reactions is incidental.

Emphasis is also placed on the inadequacy of thinking of allergic responses as being antigen-antibody reactions of a classic nature. Hypotheses are presented involving genetic and biochemical concepts with the conviction that through the pursuit of such fundamentals will come clarification of the mysteries of allergy and be extremely important in the field of cancer research as well.

THE DERMATOLOGIC APPROACH

With the atypical or difficult to diagnose case of atopic dermatitis the following are considered in differential diagnosis: psoriasis, parapsoriasis in its various forms, secondary syphilis, drug eruptions, seborrheic dermatitis and Leiner's disease in infants. With infantile eczema or atopic dermatitis the clinical picture usually suffices to establish the diagnosis. In some cases, depending on the stage of the disease, diagnosis may be difficult. The history is significant in that there is usually allergic disease in the family. There may be a strong family history of asthma, hay fever, ulcerative colitis or eczema. In infancy there is first fine vesiculation which soon ruptures to produce superficial crusts. The lesions are moist and weeping. A pyoderma may develop and the lesions appear impetiginized. Involvement of nummular patches of the cheeks occurs, which soon become confluent and generalized, particularly if there is a seborrheic dermatitis. One sign which I find helpful is the multiple folds of the skin of the lower eyelid. These folds of the eyelid give the individual a tired, wan appearance. Discrete, lichenified patches of the anticubital and popliteal areas are generally diagnostic. The neck and face are the next most frequent sites of involvement. Through a process called autosensitization (the exact mechanism of which is not understood) new areas for generalization may occur. This leads to generalized exfoliative dermatitis, which requires masterful therapy.

Dermatologic management of atopic dermatitis embraces topical and parenteral therapy. The therapy indicated is a matter of clinical judgment. For the serious case, the extensive disabling form of the disease, masterful therapy with corticosteroids is necessary. Effec-

tive sedation and antibiotics may be needed. This should imply reasonably close supervision or hospitalization. Checks for weight gain or loss, fluid retention, increased blood pressure, potassium depletion, sodium gain and stimulation of adrenals with ACTH where necessary should be routine. Gradual reduction of dose of corticoids, depending on clinical improvement, is started. Complications, particularly osteoporosis, gastric irritability, pulmonary infections, abscess formation, superficial staff infections, should be suspected continually. When carried out properly, this management produces excellent results without complications. However, too often patients assume control of their management on their own. Pills are given to friends and neighbors and trouble does occur. Mild sedation and antihistamines help wean these patients from corticosteroids. For the simple case, topical therapy is the treatment of choice. This should be bland. Avoid topical preparations containing tars, caine derivatives, or antibiotics. Compresses, using weak boric acid solution, Burow's solution,† or plain tap water are effective temporarily. Topical cortisone preparations are helpful. Lotions are generally better than the ointments, particularly in intertriginous or moist areas. A new preparation is now available. It is a water soluble hydrocortisone powder‡ in aerosol spray. It is effective and covers large areas. This is especially indicated for extensive inflammatory dermatoses where there are contraindications for parenteral corticosteroids.

THE PSYCHOLOGIC APPROACH

A PREDISPOSED person when exposed to unexpressed tensions and reality stresses will show a marked exacerbation of his atopic dermatitis. Many papers have been written to emphasize the psychosomatic aspect of this disease. Many others have been written contradicting this approach. Those who oppose the psychosomatic approach do so on the basis that nothing can be done. This is not entirely true, though the psychosomatic approach may be impractical.

Full-time individual psychiatric management is extremely expensive and time consuming. Patients who have it do better. But for practical purposes, group psychotherapy or supportive psychotherapy in the hands of the allergist, dermatologist, or general practitioner is the final answer at present. The doctor who tries this approach must be careful not to stir up too much charged material at one time. Understanding or special training in the basic fundamentals of psychiatry are essential. Deep-seated unconscious emotional factors can be drawn out properly by the experienced individual. But if the therapist is awkward about it, this can be a very messy procedure. The untrained practitioner should no more attempt this approach to disease than the surgeon should try hypnosis or the internist attempt a lobectomy. Many atopic patients are keen, sensitive, rejected individuals. Factors which point toward maternal rejection are ten times more common in the atopic group. Understanding, sympathy and kindness are essential. But a great shield is necessary to protect the physician from the aggression that is thrown his way in order to cope with the various moods that are characteristic of this group.

In summary, then, medical management, attention to allergic factors, palliation with topical or parenteral corticosteroid therapy and supportive psychotherapy will keep atopic dermatitis under reasonable control.

†Aluminum acetate solution, U.S.P.
‡Supplied by Chas. Pfizer and Company through the courtesy of Dr. Michael Carlozzi.

462 Harrison Street

George Kostant, M.D.

Irvington

Treponemal Tests in the Serodiagnosis of Syphilis*

Since syphilis is becoming less common, the non-specifically positive serologic tests are becoming relatively more frequent. This presents a potential of error, wrong treatment or embarrassment. In this brief paper, Dr. Kostant outlines procedures for meeting the problem of false positives

Recognition of the problem of the biologic false positive reactor has emphasized the need for more specific serodiagnosis in the differentiation of the non-specific from the true syphilitic reaction in the standard serologic tests for syphilis. Moore [1] has said that 40 per cent of the positive reactors obtained in mass serologic surveys in certain areas of the United States represented non-specific or biologic false positive reactions. With the introduction of penicillin and other treponemicidal antibiotics, syphilis has decreased in frequency. This means that there must be a *relative* increase in these non-specific reactions. Furthermore, persons who have a biologic false positive reaction of long duration may be candidates for serious systemic disease, especially those of the collagen vascular group, as lupus erythematosus. As clinicians, it therefore, behooves us to investigate these individuals from this point of view when syphilis has been ruled out.

Moore and Mohr [1] have conveniently classified non-syphilitic reactions into two categories; acute and chronic biologically false positive reactions. The acute BFP† reactions are attributed to a variety of infections, bacterial, viral, plasmodial, rickettsial, or protozoal. They appear during or subsequent to such diseases and regress spontaneously to normality within a short time, not exceeding six months. Examples are those non-specific reactions associated with virus pneumonia, smallpox vaccinations, infectious mononucleosis and malaria. Titers obtained in these situations are usually low, and quantitative serologic studies will demonstrate a gradual decline to seronegativity without antisyphilitic therapy.

Chronic BFP† reactions are those positive results in serologic tests for syphilis in non-syphilitic individuals which persist for years, or perhaps a life time. These reactions are *not* associated with the precipitating causes noted in the acute BFP† reactions. These reactions may be an indicator of serious systemic disease. Moore [2] studied the etiologic background of 148 chronic BFP† reactors. More than 40 per cent of such individuals had proved or strongly suspected collagen vascular disease of one type or another, particularly systemic lupus erythematosus. Rein and Kostant [3] dem-

*Read May 20, 1958 before the Section on Pathology at the Annual Meeting of The Medical Society of New Jersey.

†BFP means "Biologically false positive."

1. Moore, J. E. and Mohr, C. F.: Biologic False Positive Serologic Tests. J.A.M.A., 150:467 (1952).
2. Moore, J. E.: Chronic BFP Reactors. Bulletin on Rheumatic Diseases, 6:8 (April 1956).
3. Rein, C. R. and Kostant, G. H.: Lupus Erythematosus. Arch. Derm. & Syph., 61:898 (1950).

onstrated the frequency of BFP† reactions in all varieties of lupus erythematosus, including the chronic localized discoid type. They found an aggregate frequency of 35 per cent in the examination of 178 serums with these diseases, using a battery of six serologic tests for syphilis. It was recognized, moreover, that such serologic phenomena may be the first and only sign of lupus erythematosus and may warn of impending clinical activity. Haserick, and Long [4] enlarged upon this observation and reported five cases in which BFP† reactions antedated by one to seven years the onset of clinical manifestations of lupus erythematosus. Leprosy is another disease regularly associated with chronic BFP† reactions.

In view of the increasing importance of BFP† reactions, serologic tests for syphilis using specific treponemal antigens have been devised in the past ten years in an attempt to differentiate these reactions from the true syphilitic one.

THE IMMOBILIZATION TEST

THE forerunner of all these procedures is the *Treponema Pallidum Immobilization* (TPI) test devised by Nelson and Mayer [5] in 1949. These workers recognized that syphilitic serum contained an antibody which immobilized virulent motile spirochetes *in vitro* in the presence of active complement. The organisms employed in this procedure are harvested from rabbit syphilomas after injection with the live Nichols strain of Treponema pallidum. A positive test consists in the demonstration under the dark-field microscope of immobilization of these motile organisms by the antibody in syphilitic serum. In syphilitic infection immobilizing antibody develops slowly. In 50 to 60 per cent of primary syphilis patients, this antibody may be demonstrated. In the secondary stage and beyond, practically all patients have positive TP immobilization tests. This holds true, moreover, in all patients with congenital syphilis. While this procedure has become most widely accepted in the differentiation of true from non-specific serologic reactors, it has numerous drawbacks. Since living treponemata are used, it is necessary to maintain animals from which these micro-organisms are harvested. There is therefore, always the potential danger of accidental syphilitic inoculation of laboratory workers. Serums examined with this test procedure must be collected and handled with sterile precautions. Moreover, the presence of penicillin or other treponemicidal antibiotics interferes with the test. In addition, the test is difficult, time consuming, and requires the tedious counting of spirochetes under the dark-field microscope. For these reasons, together with the high cost of antigen, the T P. immobilization test is not suitable for mass testing. With this in view, modifications of the procedure using killed organisms and extracts of organisms, have been developed.

THE IMMUNE ADHERENCE TEST

WHEREAS the TP immobolization test uses live treponemata, Nelson's Treponema Pallidum Immune-Adherence Test [6] (the TPIA) uses killed treponemata as an antigen.[7] These organisms are harvested from rabbit syphilomas in the same manner as those used in the immobilization test. However, they are heat killed, stored under refrigeration and may be distributed to small serologic laboratories. The principle of the TPIA is the adherence of the nonliving micro-organisms to human red blood cells in the presence of syphilitic antibody and active complement. In a positive test, the treponemes are absent from the supernate because they are attached to the erythrocytes in the sediment. While the use of dead spirochetes eliminates some of the problems connected with the use of motile micro-organisms, there are certain disadvantages to the TPIA test. A number of serums obtained from BFP† reactors, espe-

4. Haserick, J. R. and Long, R.: Systemic Lupus Erythematosus. Ann. Int. Medicine, 37:559 (1952).
5. Nelson, R. A. and Mayer, M. M.: Immobilization of T. Pallidum. J. Exper. Med., 89:369 (1949).
6. Nelson, R. A.: The "Adhesion-Disappearance Phenomenon." J. Clin. Invest., 32:592 (June 1953).
7. Nelson, R. A.: The Immune Adherence Phenomenon. Science, 118:733 (1953).

cially in cases of lupus erythematosus, gave a syphilitic type of immune adherence, when antigen preserved with phenol was used. For this reason, it is necessary to adsorb the antilipidal Wassermann-type antibody from all serums prior to testing with the TPIA procedure. This is done by the addition of an excess of lipid VDRL antigen to the serums tested. As with the immobilization test, the TPIA procedure has the obvious disadvantage of requiring the tedious counting of spirochetes with the dark-field microscope. Therefore, it is not suitable for use in large-scale testing.

COMPLEMENT FIXATION

The Treponema Pallidum Complement-Fixation (*TPCF*) test (devised by Portnoy and Magnuson [8]) uses an aqueous desoxycholate *extract* of the Nichols stran Treponema pallidum as an antigen. Since the lipidal component of the spirochete is discarded, this antigen has excellent specificity. The test is a simple complement-fixation procedure based on the one-fifth volume Kolmer-Wassermann technic. It has the advantage of greater sensitivity than the immobilization test in early syphilis, as well as simpler execution and therefore greater adaptability to mass performance. Nevertheless, as in the immobilization and TPIA tests, the production of the antigen requires the harvesting of spirochetes from rabbit syphilomas. The resultant expense of this antigen precludes its general use in routine hospital laboratories. For this reason the development of a specific serologic test for syphilis using an antigen derived from inexpensively produced treponemes becomes extremely important.

REITER PROTEIN TEST

The Reiter Protein Complement-Fixation (RPCF) uses as an antigen a protein extract of the Reiter strain spirochete. This is cultivated on artificial medium. The technic used is identical to the one-fifth volume Kolmer technic as used in the TPCF test. The antigen is prepared by cryolysis of the cultured spirochete according to the method of D'Alessandro and Dardanoni.[9] Cannefax and Garson [10] and Rein and his coworkers [11] have demonstrated excellent sensitivity and specificity using this procedure. Recent studies by Kostant and Kelcec [12] comparing the RPCF with the TPCF in a group of patients with all stages of syphilitic infection indicated a comparably high level of sensitivity of the Reiter protein complement-fixation test. Moreover, 100 per cent specificity was observed in a group of normal patients and non-syphilitic biologic false positive reactors. The antigen in this procedure is derived from cultured spirochetes. This reduces the resultant cost of the antigen approximately one-hundred fold. If there is further confirmation of the excellent sensitivity and specificity of this test procedure, it is likely that the RPCF may be widely adopted for mass serologic testing.

COMMENT

THE prime indication for the use of any or all of these specific treponemal procedures is the differentiation of the *chronic* BFP† reactor from the patient with latent syphilis. In the *acute* biologic false positive reaction repeated quantitative *standard* serologic tests will demonstrate a gradual decline to seronegativity usually within a period of three months, rarely as long as six months. In the management of individuals with questionable serologic tests, syphilis should be ruled out by history, physical examination, spinal fluid

8. Portnoy, J. and Magnuson, H. J.: Fractions of Virulent Treponema Pallidum. J. Immunol., 75:349 (1955).

9. D'Alessandro, G. and Dardanoni, L.: The Protein Antigen of the Reiter Treponema. Am. J. Syph., Gonor. & Ven. Dis., 37:137 (1953).

10. Cannefax, G. R. and Garson, W.: Reiter Protein Complement-Fixation Test for Syphilis. Pub. Health Rep., 72:335 (1957).

11. Rein, C. R., Kelcec, L. C., D'Alessandro, G. and de Bruijn, J. H.: Reiter Protein Complement-Fixation Test for Syphilis. In press.

12. Kostant, G. H. and Kelcec, L. G.: An Effective Simplified Serologic Test for Syphilis Employing Reiter Protein Extract. In press.

and cardiovascular investigations. Attempts should be made to discover conditions which are capable of producing BFP reactions. Where this investigation is inconclusive, the TPCF, TPIA, RPCF or Treponema immobilization procedures should be performed. If adequate facilities are not available to perform these tests, or if there is poor patient cooperation, antisyphilitic therapy should be administered to prevent the possible development of late syphilitic sequelae. The chronic BFP† reactor may be correctly identified even after, and in spite of, antisyphilitic therapy.

A *negative* treponemal test rules out syphilitic infection except in (1) primary syphilis where it may be negative in 40 to 50 per cent of the cases and (2) in *treated* early syphilis where a previously positive reaction may be rendered negative by therapy.

A *positive* treponemal test indicates that the patient *has* or *has had* a syphilitic infection with two exceptions: (1) The syphiloid diseases of yaws, bejel and pinta will give positive treponemal tests. (2) In the newborn a positive treponemal test may indicate a passive transfer of antibody, similar to passive transfer of Wassermann-type reagin antibody.

It should be emphasized that these procedures may *not* be used by the practitioner as a criterion of cure or activity of the syphilitic process; nor can they be used as an indication for retreatment in seroresistant cases.

CONCLUSIONS

1. Attention is directed to the increasing importance of biologic false positive reactions in standard serologic tests for syphilis.
2. The Treponema Pallidum Immobilization (TPI), Treponema Pallidum Immune-Adherence (TPIA), Treponema Pallidum Complement-Fixation (TPCF) and Reiter Protein Complement-Fixation (RPCF) Tests are described as methods for differentiating the BFP reaction from the true syphilitic one.
3. The advantages and disadvantages of these four test procedures are discussed.
4. The evaluation and interpretation of results of treponemal tests are outlined.
5. It is emphasized that the prime indication of serologic tests employing treponemal antigens is for the differentiation of biologically false positives from true syphilitic reactions, and that these procedures may *not* be used as criteria of cure or syphilitic activity.

987 Sanford Avenue

Your Certificates Must Now Be Photogenic

Neatly written birth and death certificates are not enough. In a recent communication, the State Registrar writes:

"The extensive use of records of birth and death now call for microfilming all certificates and using a photostatic reproduction when certified copies are required. This means that there must be good contrast between the color of the document form and the ink used for recording the required data.

"Please be sure that typewriter ribbons are replaced as soon as the ink begins to produce a pale or nondistinct impression. For the preparation of birth and death certificates use only a dark blue or black ribbon.

"Physicians should also be alerted to the need for using *fountain pens or ball point pens* of an acceptable quality. *Pale blue, green or red inks should not be used* in adding information to or signing the records."

Special Article • • •

HERBERT E. RICKENBERG, M.D.

Newark

To Parents of Children With Delayed Speech Development

Perhaps you have a little patient whose speech development is slow. Many of these otherwise normal youngsters would say something like the following if they could express themselves better. Mr. Herbert E. Rickenberg, who developed this unusual "letter," is the director of the Henry C. Barkhorn Memorial Hearing and Speech Center at the Newark Eye and Ear Infirmary. If you don't bind your journals, we suggest you cut out this page and save it. It may explain the problem to the parent better than anything in the textbooks.

Dear Son or Daughter:

So you won't cooperate with your parents in making "meaningful speech!" Instead of your trying to learn our language, you want to teach your mother and father a language of your own. Knowing your mother and father, I can imagine how obstinate they can be, at the same time permitting you to spoil them.

To help mother and dad learn speech, I suggest that you talk to them at great length. Especially mother, since she is with you most of the day. Talk to mother, attempting to make her conscious of the fact that speech is a communicative process. This will help. For instance: don't give mother whatever she points to—make her say the "name" or word. At first, she may cry, upon finding out that you will not reward her with the object by just pointing to it. Let mother cry for a while (not to the point of a temper tantrum), then present the desired object to her, naming it as you do. This may happen two or three times, but if you do it with all the objects mother points to, she will begin to understand. (If you find that dad does not respond properly, at the same time, then you will have to perform the same tedious task with him.)

Son, you must remember that, at first, mother and dad just will not say the word properly. If they should say part of the word correctly, and then use the same sound again, to mean the same thing, give them a chance. They will learn the whole word within due time. To illustrate what I mean by this previous notation—if the object is a ball, and mother says:—baw—that will be acceptable for the present. Later on, when mother wants the ball again and she says baw, then we can assume that we have taught her a new word. Hand the ball to mother, saying the word properly: "BALL." Do not correct mother directly. In an indirect manner you are correcting her by saying the word properly. As you can see, *we never call attention to her speech.*

During the day, speech education must persist. As you are cleaning the house, washing the dishes, mending the clothes and cooking dinner, while mother sits and reads the magazine—talk to her. Try to persuade mother to help you in your daily tasks. Talk in simple sentences: "Dust the table," "Sweep the floor," "Sew the button on." Mother will attempt to imitate your movements and words.

How about dad? Ah, here is a totally different picture because of time. When dad comes home in the evening (if it isn't too late), sit on his lap (tearing the newspaper from his hand) and play with him. One game that all fathers like is pulling their suspenders and letting them snap back. If dad doesn't wear suspenders, he will have an expansion bracelet on his wrist watch, use that. As for speech, grab hold of dad's tie and pull, saying—tie-tie-tie—I'm sure he'll get the point.

When eating, all speech work should be informal. Do not try and elicit speech from mother and dad. When you do speak to them, use simple sentences so that they can understand you.

Take care of yourself son. Don't work too hard at trying to teach mother and dad. It's difficult but they'll learn eventually.

A NOTE TO MOTHER AND DAD

The process of speech is hard to learn when you continually thwart all progress by pointing to what you want and getting it. Why speak? It's easier pointing. Your son is attempting a task which is quite tedious. Your full cooperation is required. Pitch in mother—give up the magazine and help your son clean the house. Dad—submit your suspenders for the exploration of the basic designs of a sling shot.

Historical Article • • •

FRED B. ROGERS, M.D.

Trenton

General John Beatty (1749-1826):

PATRIOT AND PHYSICIAN*

New Jersey physicians who know about General John Beatty are proud of the fact that he is one of our professional sires. If you do not know about him now is the time and here is the place to find out.

STUDENTS of American colonial history are repeatedly impressed with the civic and communal importance of the physician. Beside the practice of his profession he was, as an educated person, often vitally interested in the public affairs of his community. This fact is evident in that of the first one hundred members of The Medical Society of New Jersey (organized in 1766 as the first provincial medical society in British North America), seventeen became members of Congress or the Legislature, seven were clergymen, five were sheriffs and four judges—all in addition to carrying on medical practice.

One of the outstanding figures in this pioneer organization was Dr. John Beatty, patriot and physician. An early member and tenth president of The Medical Society of New Jersey, he also served as Revolutionary soldier, state and national official in the early years of the United States. Largely because of his efforts, the first state medical society, shattered by war, was reformed and set on its course to the present day. John Beatty was among the 359 physicians recently listed in a Special Report of the American Medical Association on *Doctors in Government,* published in February 1957. His service as Representative from New Jersey to the Third Federal Congress (1793-95) links him to many other

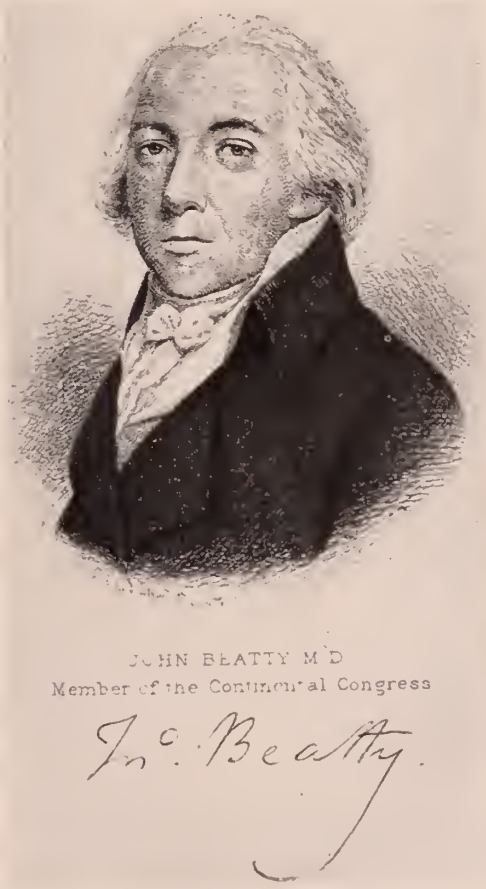


Figure 1.

*Read at the Annual Meeting of the American Association for the History of Medicine, Richmond, Virginia, May 8, 1957. The author acknowledges the assistance of Professor Henry L. Savage, Archivist of Princeton University.

Dr. Rogers is Associate Professor of Preventive Medicine, Temple University School of Medicine, Philadelphia, Pa.

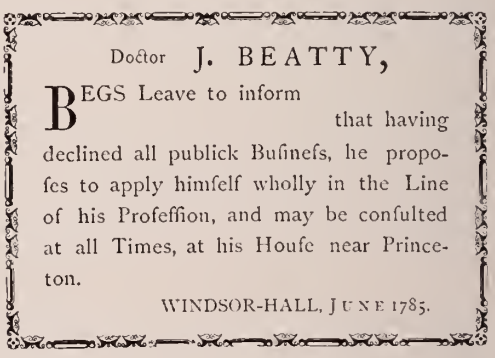
physicians who have helped to shape the destiny of this country as members of the U. S. House of Representatives or Senate.

John Beatty, eldest son of Rev. Charles Beatty, a native of Ireland, was born at Hartsville, Bucks County, Pennsylvania, on December 10, 1749. He was one of ten children born to this Presbyterian clergyman and his wife, Anne. Anne was a daughter of John Reading, a Royal Governor of New Jersey. John Beatty was graduated from the College of New Jersey at Princeton in 1769 (in the first class to graduate under the eminent Scottish divine, John Witherspoon). In 1770 John Beatty served as medical apprentice to Dr. Benjamin Rush at Philadelphia, in the first year of his preceptor's practice there. In one of Rush's notebooks, indexed under "Facts and Observations" and containing a list of his apprentices, there appears this cryptic comment — "John Beatty, Pennsylvania, 1770. Idle but worthy." In 1771 Dr. Beatty began to practice at Hartsville, his native town, and in the following year received a Master of Arts degree at Princeton.

In 1773 he returned to live at Princeton, where he practiced medicine until the outbreak of the Revolution two years later. He became a member of The Medical Society of New Jersey at its annual meeting in Princeton on November 9, 1773. In the following year he was married to Mary Longstreet of Princeton; the wedding ceremony was performed by John Witherspoon, his former teacher.

UPON the opening of hostilities in 1775, John Beatty and his four brothers volunteered for military service. All became officers in the Continental Army and one, Charles Clinton Beatty, was killed in action. John was commissioned Captain in the Fifth Pennsylvania Battalion of Infantry in 1775; during the following year he was promoted to Major and Lieutenant-Colonel in the Sixth Pennsylvania Line. In November 1776, he was captured by the British at the surrender of Fort Washington in New York. Severely treated while a prisoner of war, he was not exchanged until May of 1778. Perhaps in consequence of this experience, Beatty was appointed Commissary General of Prisoners with the rank of Colonel, after the resignation of Elias Boudinot of Princeton from this post in 1778. In this laborious and intriguing position he received explicit instructions from George Washington with regard to prisoners on parole and the exchange of captives. Because of suspicious activities related to his access within British lines with Generals Cornwallis and Grant, Beatty was arrested late in 1779 and tried on the charge of trading with the enemy. He was subsequently permitted to resign from the Army, on March 31, 1780, after receiving a reprimand in general orders from headquarters.

Returning to Princeton and medical practice, he resided at a farmhouse called "Windsor Hall," still standing on the outskirts of the town. In 1785 he was busy in practice, as a surviving professional card (printed on the back of a playing card) tells us. In 1790 he moved to "Prospect," home of Colonel George Morgan, brother of the distinguished Dr. John Morgan of Philadelphia, and now the site of the President's House at Princeton University. Known as "Doctor" Beatty in Princeton, John Beatty was subsequently called Colonel or General Beatty in public life. His Revolutionary War sword was later presented to Princeton University by the Class of 1878. You can see it there today.


Doctor J. BEATTY,

BEGS Leave to inform that having declined all publick Buſineſs, he propoſes to apply himſelf wholly in the Line of his Profeſſion, and may be conſulted at all Times, at his Houſe near Princeton.

WINDSOR-HALL, JUNE 1785.

Figure 2. Professional card of Dr. John Beatty

From November 14, 1775 to November 6, 1781, The Medical Society of New Jersey suspended its meetings because of Revolutionary



Figure 3. Bookplate of General John Beatty. Beehive device with Latin motto: "Not force, but skill."

struggles in the state. On the latter date, one month after the surrender of Cornwallis at Yorktown, five members met at Princeton to reorganize the body. The minutes of this meeting note: "Ordered that Doctors Beatty and Henderson be a committee to report the state of the Society since the year 1775." Accordingly, at the next gathering, held at Princeton on May 7, 1782, "Doctor Beatty, agreeable to the order of the last meeting, brought in a report relative to the state of the Society since the year 1775, which report being read was agreed to, and is as follows:

"That with regret we observe the vacation of six years in the Journal of this Society; and to prevent any reflections which might arise, unfavorable to its reputation in the minds of uninformed or disingenous persons, it is thought necessary to assign here the cause and reason of this suspension in medical erudition."

"The war (which has been productive of the happy Revolution in America) having claimed the attention of all ranks of Freemen, most of the members of this Society took an early decided part in the opposition to British tyranny and oppression, and were soon engaged either in the civil or military duties of the State. Added to this, the local situation of the war (the scene of action being chiefly in this and the adjoining States), rendered an attendance on the usual stated meetings, not only unsafe but in a great measure impracticable, from the scattered and distant residence of the members. Sensible, however, that improvements which would do honor to the most elevated understandings, are oftentimes hit upon by men of more confined abilities, and that in medicine, as well as in every other circumstance of life, it is our duty to avail ourselves as much as possible of all discoveries tending to the common benefit; as soon as sufficient order and harmony was restored to civil government and society, a convening of the members was deemed necessary and proper; as well as to re-establish it upon its former liberal and reputable principles, as to place it under the patronage of the Authority of the State."

Later in the same year, on November 5, 1782, John Beatty was elected President of the Society—first after its interruption by war. The minutes of the following meeting, held at New Brunswick on May 6, 1783, record: "The Society was opened by the President, with a dissertation on the blood, and the changes it is capable of undergoing in diseases." This report was continued at the next meeting on November 4, 1783. Unfortunately, it was not recorded in the Society's *Transactions* as were some of these early "dissertations."

Beatty continued to be active in the Society for a decade after his term as President. In November 1785, he was appointed Secretary due to illness of that officer. During the next ten years he contributed to the minutes and corresponded with organizing medical groups, The Massachusetts Medical Society, College of Physicians of Philadelphia, and Medical Society of New York.

Because of his surgical skill, Dr. Beatty was selected to operate upon a patient seen in consultation at the New Jersey Society's meeting on November 1, 1785. The minutes tell that:

"Jacob Probasco, a lad of 17 years, with a tumor in the forearm, was brought before the Society for their examination and advice. After due deliberation, the Society were of opinion, that whether it was a tumor of the encysted kind, or an aneurism, incision ought in the first instance to be made, with a view, if possible, to save the limb; at the same time making every preparation for an amputation in case it should be found necessary."

The next item, on the following day, was:

"Jacob Probasco, in consequence of the advice of the Society . . . attended before them and the necessary preparations being made, Doctor Beatty was appointed to perform the operation. Incision was made, a considerable hemorrhage took place (although there was no appearance of an aneurism), and the tumor was extirpated, consisting partly of carnous, ligamentous, ossian and cheesy like substances, not encysted, but lying within the common covering integuments of the arm, and occupying the whole space from cubit to the wrist."

Later minutes, in May 1786, reported that: "Four days after the extirpation of the tumor, it was found necessary to amputate the arm . . . A week afterwards, a stiffness in the neck appeared, and other symptoms indicating a lock jaw, and notwithstanding warm applications to the part and a free exhibition of opium internally, the symptoms continued increasing, the mouth was obliged to be kept open by force, and a great rigidity of the whole body and limbs took place. In this state he continued, with very little remission, for six weeks; the wound at the same time . . . had a good appearance; the symptoms then began to wear away and the cure was performed in eleven weeks. The patient now enjoys good health."

IN 1785 John Beatty was one of a committee appointed to see that, "the Fundamental Institutions and Rules of the Society be published." In the same year, and again in 1790, he was cited as an examiner for candidates requesting admission to the Society. His name also appears among fifty members listed on an Act of Incorporation for the Society of June 2, 1790, and again on an amendment to this charter in 1792.

Meeting at Princeton on November 7, 1786, the members, "Ordered that a seal be made for use of this Society, and that Doctor Smith, Dr. Wiggins and Dr. Beatty be a Committee to procure said seal, and affix what device they deem proper." From this initial proposal came the historic seal still used by The Medical Society of New Jersey.

An interesting reference to Beatty's practice appears in a letter of his preceptor, Benjamin Rush, of September 9, 1793. Writing to his wife, Julia, who had fled to Princeton to escape the yellow fever epidemic in Philadelphia, Dr. Rush reported his own illness, sleepless work among the sick, the death of his sister and three of his apprentices. He added, "The disease has awakened like a giant refreshed by wine," and directed, "Communicate this to Dr. Beatty."

During this period John Beatty was becoming active in politics, business, school and church affairs. Representative in the New Jersey Legislature during 1781-83, and delegate to the Continental Congress in 1784-85, he also represented Middlesex County in the State Convention that ratified the Federal Constitution in 1787 and was Speaker in the State Assembly of 1789. From 1793-95 he was one of seven physicians in the Third Federal Congress, serving in the House of Representatives at Philadelphia. On the expiration of his term in Congress, he became Secretary of State of New Jersey and held this office for ten years.

In 1795 he moved to Trenton and built a fine home on the banks of the Delaware River, near the present State House. He became caretaker of the State House grounds adjacent to his home and rendered them profitable by keeping pasture and cutting hay. The doctor also served as an elder in the First Presbyterian Church at Trenton and was active in Masonic Lodge No. 5 there.

HIS first wife died in 1815; three years later he married Catherine Lalor of Trenton. Two children had been born by his first wife; a daughter, Anne, who died in infancy — in a convulsion attributed to cannon fire during the Battle of Princeton, and a son, Richard Longstreet Beatty, who was graduated from Princeton in 1797 and became a prominent lawyer. In his later years John Beatty served as President of the Trenton Banking Company (from 1815 until his death in 1826) and was Treasurer of the New Jersey Society of the Cincinnati. In 1803 he was President of the Delaware River Bridge Company at Trenton.

Interested in education, General Beatty was for seventeen years a Trustee of Princeton College (1785-1802) and was Treasurer of his *alma mater* in 1787-88. He was a Trustee of the Princeton Theological Seminary during the last four years of his life.

John Beatty died suddenly of cerebral apoplexy on May 30, 1826—in his 78th year. His funeral was attended by a large group of mourners from many walks of life. He was

buried in the First Presbyterian Churchyard at Trenton where one can read his epitaph today:

"Sacred to the memory of Gen. John Beatty, born Dec. 10th, 1749, died May 30th, 1826. Educated as a physician, he early became distinguished for benevolence, assiduity, and skill. In the War of Independence, in important military stations, he faithfully served his country. By the public voice, he was called to the discharge of eminent civil offices. In the State and National Legislature repeatedly a representative, and always active and influential. For many years a ruling elder of this church. In every walk of life, amiable, honorable and useful. He crowned the virtues of the man, the patriotism of the soldier, and the sagacity of the statesman, by the pure piety and sincere religion of the devout and humble Christian."

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Taking the Joy Out of Life

The Navy has finally developed a clinic for taking the joy out of life. Under the curious designation of Stress Clinic, the Naval Gun Factory has a unit which "centers its activities on counselling and a basic stress diet." According to an article by D. C. Lipman in the June 1958 *Industrial Medicine and Surgery* (27:295), the clinic has developed a regime which avoids animal fats, irritants, salt and stimulants. Also eliminated by this busy clinic are soda, alcohol, coffee, salt, tobacco and ice cream. However, the clinic does offer some compensations. Thus, they do provide nasal irrigation, antihistaminics and neck traction. The clinic's counselling is based on its observation that week-ends and holidays are not used by employees for rest and relaxation. This incredible discovery leads to the conclusion that employees use their holidays "for the abuse of their outside interests and activities." The clinic is now hoping to do something about these week-ends and holidays.

Symposium on Medical Care Coverage*

Dr. Daniel F. Featherston: Ladies and Gentlemen: It is with a great deal of pride that we present to you the gentlemen tonight who, we think, are masters in their respective fields.

Our President's inaugural address kept philosophy in medicine at a very high level. Now let's get down to cases because we do have to eat; we do have to live. Let's talk about dollars and cents.

In 1951 the Prudential Insurance Company decided to enter the individual policy accident and sickness insurance field. To head this new and important branch of business they chose the next participant on my panel. In this short period of time the Prudential has become the largest writer of non-cancellable, guaranteed renewable health insurance in the United States and is one of the largest writers of any form of health insurance. Ardell T. Everett, Chairman of the New Jersey Health Insurance Council, is active in several important national health insurance committees. A tremendous amount of his time is spent in legislative and industrial activity to broaden and improve the health insurance coverage so as to preserve the voluntary choices as opposed to the federal compulsory health insurance plan. "Dell" is a graduate of the University of Denver and has been in the insurance business for 28 years. At the present time he is Second Vice-President of the Prudential Insurance Company of America.

Ladies and Gentlemen, Mr. Ardell T. Everett.

(Applause)

Mr. Ardell T. Everett: Thank you, Chairman Dan.

Ladies and Gentlemen: I had a fine speech written to give to you, but unfortunately while you have been enjoying yourselves in Atlantic City some things have happened that have caused me to have a problem and I want to tell you a little story, if I may, about the problem.

A lovely young man married one of a set of beautiful twins, voluptuous, most redheaded lovely creatures. As they stood at the wedding ceremony his best man shook his head and he said, "My goodness, they are identical. You have a problem." He said, "I don't have a problem."

So they went on their honeymoon and they came back. The best man ran into the bridegroom and he said, "Where did you go on your honeymoon?" He said, "We went to Bermuda. My wife's father paid my sister-in-law's expenses and so the three of us went to Bermuda on my honeymoon." He said, "Brother, you do have a problem." He said, "I don't have a problem."

So about a year later the bridegroom ran into his friend on the street. He said, "Well, how is everything going?" He said, "Fine. We just moved into a new home." "Well," he said, "tell me about your beautiful sister-in-law." "Oh, she's living with us." And he said, "Well, your wife and she look identical." He said, "How can you tell, as you move around the house, which is which? You really have a problem." He said, "My friend, I don't have a problem. They have the problem." (Laughter)

Well, my problem is that some things happened while you were enjoying yourselves in Atlantic City and you failed to read the newspaper dated last Friday.

(Uncovering enlarged newspaper.)

That's the *Daily News* dated May 17, 1958. As you see, "Congress Passes Health Bill Covering All Citizens."

Well, Dr. Ken, your remarks were well in order, but a little too late.

What does this mean to you? As soon as the government can form their administrative councils, they will tell you where to have the meetings and who can attend. It might not be Atlantic City and maybe you won't be able to bring your wives. They will tell you where to practice and how to practice. Your fees will be set by, or your income will be paid by government. They will determine the quality of medical care and your professional proficiency. This same bill encompasses taking over the hospitals of America, your laboratories, the places where you have learned so much to help the health of the American public. They will determine what experimentation can take place. They will help you only by saying that these folks go to the hospital. You won't be able to put them there. You will have to apply for your patients. They will send your patients in to you in droves,

*General Session, 192nd Annual Meeting of The Medical Society of New Jersey, May 19, 1958.

whether they need help or not. The freedom of choice will not be yours or the patient's, but Government's.

I hate to tell you this story. You can relax. It is fictitious. But it isn't fantastic.

(Uncovering another enlarged newspaper.)

Here are the headlines that appeared on the *Globe and Mail* in January in Toronto, Canada: "Frost Hospital Care Plan Offered To All In Ontario. Extensive Benefits Listed." You can't read this, so I'll just brief a few of the items.

"The plan will be in operation January 1, 1959. It will provide unlimited public ward care not now available in Toronto, plus diagnostic services in the hospital. No limitation as to the duration of stay in the hospital, age or disability, thus eliminating the catastrophic aspect of illness of long duration. Protection available to everyone who enrolls. Voluntary participation at first, to be mandatory at a later date." I want to read that again: "Voluntary participation at first, to be mandatory at a later date."

Six months after January 1, 1959, all of the provinces in Canada will have federal compulsory hospital care, except perhaps Quebec. There is a story behind it. I was just talking to Dr. Allman a little about it.

Four years ago the legislation was spotted. It looked like compulsory health insurance. Several of us alerted the Canadian insurance agencies. A telephone call was made to the American Medical Association. They in turn called the Canadian Medical Association. The Canadian doctors said, well we don't think this is going to happen, but we don't want to oppose it because it doesn't include medicine as such. The Canadian public was completely apathetic; and the Canadian doctors were completely apathetic and the Canadian industry generally was completely apathetic.

On January 1, 1959, and I can't speak for the entire industry, every company that has voluntary insurance in force in these provinces and in Ontario particularly will be cancelled and taken over by the government.

It's just across the border, and this is the last place left. We are really very worried about it. The apathy of the public in respect to your problems and our problems, and they are united, is terrific.

Further and a matter of deep concern to us, Ontario Blue Cross, next January, for all intents and purposes, will become the administrative agency of the Province they have just taken over.

In Manitoba they have just passed a law that you either come into this plan or if you go to the hospital without having paid premiums you will be fined. Every person in Manitoba will be fined $200, whether they want this health coverage or not. Then they'd have to pay the entire hospital bill before they can re-enroll. The public is really upset now, but it's too late.

We know that with any kind of government subsidy of health insurance comes control. Individual initiative is stifled, if you will think about it. Over-utilization of services always occurs, and the minimum benefits tend to be maximum. The cost of any government plan we have studied has always exceeded the original estimate.

Three quick examples. Three of the provinces in Canada have had provincial plans. The average length of stay in these provinces per person confined is 10.1 days. In the United States it is 7.9 days. They can't get them out of the hospitals. It's suggested that when people are put in, they are not really interested in health; they just stay there. The government has to get them out.

I want to give you two examples of cost over original estimate. The estimated gross cost of the English National Health Service for the year 1958 will be two billion dollars or more. Four-fifths of it now comes from general tax funds. This compares with the original estimate for this same period taken five years ago of $490,000,000—four times as large.

One Canadian report referred to the British-Columbia plan. In the first year the taxpayers had to bail the plan out for $3,700,000 on a total expenditure of $15,900,000. At that point people paid premiums under the provincial health plan. They have now had to increase their general sales tax and the general revenue tax to take care of a $47,800,000 bill without any personal premiums. This is last year. The program is now completely tax supported. Health care alone accounted for 23 per cent of the total net general expenditure of that province in 1955, and it is more now. I want to repeat that. Almost one-quarter of the province's entire net general expenses went for this expensive health care plan; more than roads and schools together.

The only way that we will ever get the American public to understand that we don't want any is to point out that it is going to cost too much. It can bankrupt and has almost bankrupted five nations. When the average person realizes that he is going to be taxed to death, he is going to be a little afraid of it. And when he understands that you can't give him the quality of medical care, that he has

no choice, he is going to be concerned. But you can't get him interested in the problems of the medical societies or the problems of the insurance companies. It has to be the net result to him.

I wanted to give you that brief background for two reasons. The American insurance companies have been somewhat apathetic until we have seen what has happened elsewhere. I can report to you that they are working very hard along with the other voluntary insurers—your Blue Shield and the Blue Cross —to see that everyone has adequate health protection. We know that a great many of the provisions of contracts are perhaps not individually satisfactory to you, and all I would say in pleading to you to understand that any insurance in order to be successful has to be actuarially sound; it has to be a plan of averages—the high fee and the low fee and the middle fee—and then you have to figure the incidence and then you can make a rate. We are all going to have to give a little. We want to learn from you and we are trying.

Within the last few years we have heard many doctors say: "I don't care anything about these plans because they don't reimburse me for my particular skill or my specialty." That's probably true, because we have to walk before we can run.

There has come on the horizon what is known as major medical insurance. We are all experimenting with it. We are experimenting with it with you. Major medical insurance is a type of insurance that covers not just surgery in a hospital; it covers all parts of medicine and nursing care both pre-hospital, post-hospital or not in the hospital. It will take care of the major catastrophy of the person up to, in many instances, ten to twenty thousand dollars of total health and hospital bills.

It is designed with a deductible amount first, sometimes $100, sometimes less, perhaps $50, to eliminate the small claims which are expensive to administer and let the person take care of his initial part of his bill. Then after the deductible is satisfied—and I don't want to be complicated—everything goes into the quotient of insurance with a co-insurance factor. Co-insurance means that the insurance companies will pay 75 per cent or 80 per cent of the remaining total of the bill and the individual pays 20 per cent. We feel it is important that he should have an interest in his insurance.

It can be written on top of service plans, as you know. We think it may be the answer to the problem of helping America to be covered. It means that there are no set schedules within this plan, which means that we must ask of you to tell us what is a reasonable fee upon which we can base a rate. The plan for the insurance industry can be priced out of the market by abusive charges.

Now, I only want to say one thing in closing. Many of you have said to me and other associates: You have too darn many claim forms. Well, there are a thousand companies writing health insurance. More and more of it is taking a greater part of your income or giving you part of your income.

The Health Insurance Council that Dr. Featherston mentioned is an organization of all of the insurance companies writing over 90 to 95 per cent of all the health insurance in the country. We have adopted within this Council standard forms. We are urging the companies to adopt them, and most of the larger ones have. The questions will be standardized. There will be a Health Insurance Council form that will have a single HIC on it; as companies have used their present supply of forms, we expect that this will start coming to simplify your job.

We are working with your New Jersey committee. We are working with doctors in over forty states on Health Insurance Council activities. We think that together our problems are equal and we think together we can lick them. We stand or fall together.

Thank you very much.

(Applause)

Dr. Featherston: Thank you, Mr. Everett.

I'm sure that we can feel safe and a little bit happy that the insurance industry of America is now interested to the extent that Mr. Everett indicates in the doctrine that we need them, they need us, and I'm sure it will be mutually satisfactory. It should be and we can make it so.

Those of us who were in the recent unpleasantness, whether Army or Navy, know the catch-phrase, that you got promoted by luck and location. Well, the doctors who were there knew that you had to be quite a doctor to get to be a Major General. We have with us tonight a gentleman who is not only an excellent doctor, from his background material, but his rank proves, I think, a success in addition to a background of medicine which is extensive. He has success in the administrative field that is above and beyond what you would reasonably expect a doctor to have. I am sure he wouldn't want me to take up your time, with all of his achievements in the United States Army, but at the present time

he is the Executive Director of the Dependents' Medical Care Program—Medicare to you. He had, if I am not mistaken, a large part in its formation. He is the administrator of the plan. He therefore, I'm sure, has the background to tell us most everything that there is to know.

Ladies and Gentlemen, Major General Paul I. Robinson.

(Applause)

General Paul I. Robinson: Dr. Featherston, Dr. Gardner, Dr. Allman, Distinguished Panelists, Ladies and Gentlemen: I am pleased to discuss the Medicare Program in the light of achievement and challenge because it affords an opportunity to add to our enlightenment. Medicare is a small program when compared with all the medical service rendered in the United States. The combined hospital and physicians' billings are now somewhat less than $7,000,000 a month or approximately $77,000,000 per year; yet the program is so widespread that one-third of the nation's physicians have accepted at least one case in the first year and a half of its operation and four or five physicians in each state have received remuneration of substantial amounts—$8,000 to $30,000. The large majority of this 33 per cent of the nation's physicians have cared for not more than two or three Medicare patients.

The Medicare Program has been in effect barely one and a half years. As many of you know, it has afforded much interest among all groups and associations within the profession of medicine. Members of my staff and I have made many public appearances in physician and hospital meetings and have been confronted with many opinions and ideas. In general, the controversial areas might be said to be in five general categories:

Are physicians' charges too high?
Is Medicare disrupting local Blue Shield?
Is Medicare fixing physicians' charges?
Is Medicare socialized medicine?
Is the Medicare Plan too rigid?

In discussing these areas of controversy, it is appropriate that we first review briefly the Medicare Plan. It is an individual plan with characteristics of its own. It does not conform to any Blue Shield or insurance health plan which we have seen. It incorporates deductible, indemnity, and full coverage features.

The patient must be the wife or child of a serviceman on active duty or a truly dependent husband of a servicewoman. The patient has free choice of physician; must pay a stipulated amount which is related to the hospital bill for in-patient care and to the physician's charge for authorized out-patient care. The need of these patients for assistance in the payment for medical care is unquestioned.

Medical care is limited. No out-patient care is authorized except that related to maternity care and that necessitated by bodily injury. Care for chronic diseases, nervous and mental diseases and elective cosmetic surgery is not authorized. Dental care, except that directly adjunctive to medical care requiring in-patient treatment, is not authorized. Ambulance service is not a part of the program for any case.

The physician may accept or reject the case under the plan. He determines whether or not hospitalization is necessary. His performance and standards are those prescribed by the local medical authorities. His charge may be his normal one for those of $4500 income, or that listed in the negotiated schedule of allowances, whichever is less. For unusual time and effort, he is entitled to submit justification for additional amounts to the Government. The applicable schedule of allowance is that negotiated between the State Medical Society and the Office for Dependents' Medical Care and is designed to be fair and reasonable. The schedule may be said to be a necessary vehicle to permit economical processing of claims by clerical personnel.

The hospital likewise may accept or reject patients under the plan. Hospitals must meet a definition which is essentially that required by the American Hospital Association for listing. The standards of care furnished are those established by local jurisdictions. Billings are based on Blue Cross preferred rates or regular charges in accordance with local arrangements with fiscal administrators.

Payments are made to both hospitals and physicians by fiscal administrators who are under contract to the Office for Dependents' Medical Care. Physicians are paid by Medical Societies, local Blue Shield Plans or private insurance companies; hospitals by Blue Cross or private insurance companies. All, except some medical societies, are normally in the business of paying for medical care and all perform this service on a cost basis. In most instances, payments are made from funds which have been advanced by the Government and on which the fiscal administrator pays no interest.

Questions and additional charges are normally adjudicated by a designated committee in each state and passed to the Office for Dependents' Medical Care for action. Final de-

cisions are made by highly qualified physicians in my office who are at liberty to consult with consultants in all four of the Surgeons Generals' offices and with civilian physicians as well. As you can well imagine, the great bulk of these decisions are to determine whether the procedure or treatment is covered by the law; and most such decisions are in the chronic disease, nervous and mental category and in elective cosmetic surgery categories.

Prior to World War II, our nation had always maintained small armed forces under the belief that civilians could be trained to man our Army, Navy and Air Force after hostilities were imminent. These small forces were stationed on military posts where adequate medical service was maintained. Thus, the traditional medical service which has been rendered to the dependents of our Armed Forces since the days of Indian garrisons was made available. But, since World War II, it has been considered necessary and wise to maintain rather large armed forces. For the proper defense of our nation, many small Army, Navy, Marine and Air Force units have been established and located at some distance from the established posts, camps and stations. I refer to the Niki sites, the small air bases, and the military districts. Some 40 per cent of our forces are so located, or have been unable to receive medical care in Uniformed Service facilities because of inadequacy or over-crowding. Prior to December 1956, the Government was not rendering traditional medical service to the dependents of this group. Morale was adversely affected, men were not re-enlisting; indeed, they were resigning. The continual training of men in the complicated specialties of defense was expensive and our Congress felt this failure to provide traditional medical service for dependents of servicemen should be corrected. The Congress did not choose to build many small medical facilities and draft doctors. Instead, it decided to design a plan which would be acceptable to the physicians and hospitals of the nation and remunerate them fairly and justly for this service. This is a true evaluation of the Medicare Plan and may be confirmed by any of you who read the hearings on the bill before it became law.

Are physicians' charges to the Government for care of Medicare patients too high?

Lacking a standard for physicians' charges, this is a most difficult question to analyze. That physicians' charges are too high has been stated by many urban physicians who contend that the rural physician has never before, and does not now receive from his private patients fees comparable to those of Medicare. The rural physician, however, says that he renders just as good service and thus is entitled to the same fee as the city physician. He further asserts that his collections are lower because of the economy of his locality and that he should be able to balance up somewhat by the larger allowances of Medicare. A considerable number of physicians believe the allowances to be too low because they charge more to their private patients. Some Government officials believe physicians' charges are too high. In the Medicare Program, the total charge to the Government is approximately 50 per cent hospital charges and 50 per cent physicians' charges. In Government hospitals, the proportion of the total charge attributable to physicians' salaries is much lower. Others contend that, since the Medicare Program is essentially a surgery and maternity program for young women and children with an average 5.4 patient-day stay in the hospital, the physician cost must be considerably greater than in Government medical care facilities.

We have published average physicians' and hospital charges from time to time during the past year and a half. I have presented these charges at several medical meetings. It is my belief that the physicians of the nation can and will do something about it if physicians' charges become unreasonable.

The Medicare Plan provides for payment of the physicians' normal fee, or the amount in the Schedule of Allowances, whichever is lower. Ten states have already taken action. They have not published their negotiated schedule. They have told physicians the schedule is reasonable and to submit their normal charges. There are no more requests for additional fees from these states than from others and the physicians there appear to be generally satisfied.

Is Medicare disrupting Blue Shield?

I never feel competent to discuss this question because of my limited knowledge of Blue Shield plans. I have learned that there is a great deal of difference between various plans. Having worked with medical societies and fiscal administrators for Medicare for the past one and a half years, I have found that many Blue Shield plans are not completely satisfactory to the physicians. It has been my personal observation, in those areas where a completely satisfactory Blue Shield plan is in operation, that Medicare has not been a disrupting influence. It has also been my feeling that the Medicare schedule has been used, or that attempts have been made to so design it, as a wedge to force changes in Blue Shield plans

in those areas where considerable dissatisfaction was prevalent. I would like to emphasize again that Medicare is a plan unto itself, designed in a special way to serve a special purpose and, in my opinion, should not be considered as a Blue Shield plan.

Is Medicare "fixing" physicians' charges?

Again I would like to refer to the basic concept of the Medicare Plan which provides for the physician to charge his normal fee, or that in the Schedule of Allowances, whichever is lower. Only the state medical authorities know the facts concerning physicians' charges. If the State Medical Society uses the Medicare schedule as a "fixed fee" and patterns other programs like it, then of course it can be the forerunner to "fixing" physicians' charges. It is the sincere hope of those of us having to do with the administration of the program that this will not happen. It is within the control of the state medical associations to prevent this from occurring.

Is Medicare "Socialized Medicine"?

Some say that any health plan for which the Government pays is "socialized medicine." Others say that any program which permits the profession to exercise jurisdiction of the policies of medical practice and the supervision of its own members is not "socialized medicine" even though the Government pays for the service. Medicare meets these qualifications. It is my belief that all are sincere in their statements. But there is a marked difference of opinion as to the definition of "socialized medicine." I do not believe the Medicare Program is "socialized medicine" because it was developed by the Armed Services Committee of the House of Representatives after long and careful study. It was designed to procure a service for dependents of servicemen which had been available to them by both law and tradition for a century but which was not available to them after World War II because of the changed defense structure of our nation. Also, I can say truthfully that, since its beginning, I have observed no action on the part of any segment of the Government to use the program as a basis for any program of national medicine. One would be naive, indeed, to believe that those who would sponsor a socialized medicine program would not notice the successful operation of Medicare in some areas without the benefit of guidance by the local medical authorities.

Is the Medicare Plan too rigid?

In the Medicare Plan, the physician is entitled to his usual charge, to that negotiated by the state medical society with my office, and to supplementary remuneration in unusual cases requiring additional skill and effort when justified to the satisfaction of state adjudication committees and my office. A few medical societies have said that this is too restrictive and adhere to the principle that the physician should be authorized to charge the patient additionally in his own discretion and without control other than that afforded by the Grievance Committees of the state and local medical societies. It is my opinion that the Medicare Plan is a good one and that dependents will use the plan as now constituted for a considerable part of their medical care needs. I doubt that they would use, to the same extent and with the same freedom, the alternate plans which have been proposed. The Medicare Plan is flexible and workable and it is hoped that it may have a fair trial.

In 1956 there were 403,537 admissions of dependents of service personnel to Uniformed Service Hospitals. In 1957 there were 333,842; but, during the first full year of Medicare, 328,100 dependents were admitted to civilian hospitals. In other words, there was a 39 per cent overall increase of dependents cared for at Government expense. And, you will remember that the Congress considered that 40 per cent of the dependents were not receiving traditionally provided medical care because of their location, crowded and inadequate service facilities and personnel. We consider this a remarkable affirmation.

In a recent survey conducted by the Army in a number of posts, Medicare was named as one of the prominent reasons for soldiers' re-enlistments and for making the Army their careers.

Medicare is accomplishing the purpose for which it was designed. This achievement is possible only because of the general acceptance of the program by the physicians and hospitals of the nation.

The Medicare Program has presented the Government with a number of challenges: first, to design an acceptable program; second, to administer the program in an acceptable manner; and third, to provide dependents with traditional medical care. And we submit that these challenges have been well met and may soon be relegated to the achievement column.

But the Medicare Program has also presented a number of challenges to the profession.

1. Dissemination of accurate information concerning Medicare to the physicians of the nation. This is particularly difficult because such a large proportion have occasion to participate so infrequently.

2. To prevent unnecessary hospitalization.

3. To see that high standards of medical practice are utilized in the care of Medicare patients.

4. To assure that charges are fair and reasonable and in line with local custom.

5. To adjudicate fair and equitable additional charges to the Government in care of Medicare patients in those cases warranting such charges.

6. To see that Medicare schedules are not used wrongly for other programs.

7. To take steps to assure that Medicare schedules do not tend to "fix" physicians' charges.

8. To assure acceptance of Medicare in its proper perspective—encourage medical society participation, and lead the program in the right direction.

(Applause)

Dr. Featherston: Thank you very much, General Robinson.

A very interesting coincidence became apparent this evening when we were looking at some background material that was submitted on our panelists. About the time Mr. Everett was struggling to get through the University of Denver, General Robinson was taking his internship at the Fitzsimmons General Hospital in Denver. And when the General returned as its commanding officer, Dr. Borsher, our next speaker, had just finished the chest service there.

Dr. Borsher you all know. Dr. Borsher is one of our members, is particularly fitted to discuss his topic because he so recently was Medical Director of the Medical-Surgical Plan of New Jersey. He is still a member of the Board of Trustees, and I give you Dr. Irving Philip Borsher.

(Applause)

Dr. Irving P. Borsher: Dr. Featherston, Dr. Allman, Ladies and Gentlemen: I'm grateful for the privilege of speaking to you. My topic is Blue Cross and Blue Shield—achievement and challenge. To tell you the story of the achievement and challenge of Blue Cross and Blue Shield is to tell you the story of the achievement of The Medical Society of New Jersey for the past generation with respect to the economics of medical care.

In 1938 the House of Delegates of the American Medical Association adopted a resolution urging state medical societies to prepare programs of pre-payment insurance for medical services. Within three weeks of this resolution The Medical Society of New Jersey appointed a study committee to investigate the approach to carry out the resolution of the American Medical Association. The efforts and recommendations of this study committee eventuated step by step in the organization by the Medical Society of the Medical Service Administration of New Jersey for the purpose of drafting plans for medical service corporations. It was the opinion of the legal counsel of the Medical Society that this Medical Service Administration of New Jersey would, in effect, be an insurance program which would require an enabling act. The program would be under the supervision of the Department of Banking and Insurance. The legal counsel of the Medical Society, with the help of the committee, drafted the enabling act for Medical Service Corporations.

The Medical Service Administration proposed three concurrent insurance plans. The first was Medical Service Plan Number 1. This offered insurance for individuals and families for the services of physicians, both in and outside of hospital, including x-ray examination and an annual physical examination. The attempt to sell this fairly comprehensive contract failed and the plan expired.

Medical Service Plan Number 3 was for farm families. It was patterned to a certain extent on the Emergency Relief Administration that was in operation during the 1930's. During the period of the depression this was helpful to farm families. Some policies were sold, but the plan expired after one year.

Medical Service Plan Number 2 was for the insurance coverage of hospitalized illness. In those days it was considered that a hospitalized illness was a catastrophic event and this plan was considered as providing "catastrophic coverage." Quite a change has taken place since 1940 with respect to hospital admissions and this definition of catastrophic illness. It is interesting to note that this was coverage only for services rendered in hospital.

In 1942 the Medical Service Administration contacted the Blue Cross Plan, that is, the Hospital Service Plan of New Jersey. This was the first Blue Cross Plan in the country on a state-wide basis and it had begun operation in 1932. Medical Service Administration asked the Hospital Service Plan to act as its administrative agent. A joint operating agreement was drafted in 1942 so that Hospital Plan could use its employees and its facilities for the solicitation of subscribers, for enrollment, billing and collecting. The name of Medical Service Plan Number 2 was changed under that joint agreement to the Medical-Surgical Plan of New Jersey and

has eventuated in the Blue Shield Plan of New Jersey. It began its operation in 1942.

We have been frequently asked why the plan has not covered services outside of hospital to a greater extent. The reason derives from the history of these three plans. The only one that continues to exist is Medical Service Plan Number 2, coverage for hospitalized illness.

What have Blue Cross and Blue Shield achieved with respect to what The Medical Society of New Jersey has hoped they would achieve? The Blue Cross Plan currently has an enrollment of slightly over two million persons. This amounts to close to 40 per cent of the population of New Jersey. The Blue Shield Plan has an enrollment of approximately 1,700,000, about 35 per cent of the population of New Jersey. Actually the Blue Cross and Blue Shield enrollment in New Jersey amounts to more than that because of the enrollment in the neighboring Blue Cross and Blue Shield Plans in New York, Pennsylvania and Delaware, which easily accounts for an additional 10 per cent. So that we have enrolled in these plans which have been sponsored and organized by the Medical Society and approved by the Medical Society close to 50 per cent of the population as a whole.

The Hospital Plan's enrollment of over age 65 amounts to 9 per cent of the subscribers. In Blue Shield Plan the enrollment of over age 65 subscribers amounts to close to 7 per cent. This is a significant figure because the ratio of the population that is over age 65, is about 20 per cent. So that in proportion the plans have enrolled a considerable number of people who are over age 65. The reason that the Hospital Plan has a greater ratio than the Medical Plan is because it has been in operation ten years longer than the Medical Plan.

What does the public want? The public wants the best medical care that can be made available at a reasonable cost, at a price that it can afford to pay. The plans that have been established help the medical profession to achieve this desire of the public. Of the costs of hospital admissions currently the Hospital Plan covers in full at least 85 per cent of the admissions. Of the cost for eligible medical services rendered that is approximately the payment in full insofar as services of physicians are concerned. This is a great help to the public in its desire that the medical profession provide its services at a reasonable cost and on the basis of free choice of physician and fee for service.

(Applause)

Dr. Featherston: Thank you, Dr. Borsher.

The closing subject of our Panel will be undertaken by Mr. Number One in New Jersey in the medical profession. We all know him; he's been introduced so many times you probably see his name in your sleep. After achieving the Number One spot in New Jersey he moved on to a larger field, as you know, and he is now the President of the American Medical Association, for which we are all justly proud. Dr. Allman will discuss the topic from the point of view of labor and legislation. Dr. David B. Allman.

(The audience arose and applauded.)

Dr. David B. Allman: Dr. Featherston, distinguished members of the panel, my Senior Fellows, Fellow Members of The Medical Society of New Jersey, and Guests: The labor programs I will discuss first for just a moment. They are terrific. The United Mine Workers, the various clothing unions in New York particularly and on the West Coast are causing us no end of grief. We feel this is a distinct restriction of free choice of physician by the patient, one of the tenets which we have always held to be highly censorable. Labor is also very active in the legislative field and the two tie in closely together. The labor programs are no longer simply labor programs; they are becoming programs of legislation in our government. The things Mr. Everett said should be remembered by you folks. Our stenotypist has it and I hope that when it is published in The Journal of The Medical Society of New Jersey you will all read it. The things he said should be written indelibly on your mind. While some of you think of Canada as a long ways off, as far as this problem is concerned, it is very close.

You can't see on that *Globe and Mail* sheet right under where Mr. Everett was reading it says: 'Hospital plan timed for election year, Liberal leader claims." Well, it was. All of these give-away programs which our government is planning are all timed for election years. We don't have to worry much on off-years, but election year all of the Congressmen and Senators are in there to give what the people think is something for nothing. They are in Congress and the Senate because of the votes they get. They get votes by doing something for people and the public is gullible enough to believe that this is something for free. And the Congressman always wants to go back; he gets that Potomac fever, so he gives the public what they think is something for free. They give them possible hospital care or they increase the benefits under Social Security. For some reason or other even in

this highly enlightened age our people don't realize that they are going to pay for it and they are going to pay for it with a devaluated dollar because every dollar we send to Washington, you know, comes back to us either cut in half or at least one-third of it is gone. So how our citizens can buy this is beyond my power of comprehension, but nevertheless they do.

Now, again tying the labor programs in with the legislative program, we have confronting us my pet peeve, the Foran Bill.

If I may digress right here a moment, jokingly of course Mr. Everettt pulled down the first paper. You saw where "Congress Passes Health Bill Covering All Citizens." You might have read that in 1950 and darn near did if it hadn't been for the activity of the American Medical Association in arousing the state societies and through the state societies the county and local societies, and if it had not been for some very wonderful allies which we had you would have awakened some morning in early 1950 and read that in your paper.

Well, you are not going to read now that "Congress Passes Health Bill Covering All Citizens." They are doing something better than that. They are nibbling away piece by piece, a little here and a little there, taking one segment of American citizenry after another and covering them. With all due respects to Medicare that is one segment. But let me say right here and now we approved of the Medicare Program; we worked with General Robinson and the cooperation which we have had on the national level from the General has been absolutely one thousand per cent and I can't pay tribute enough for working so wholeheartedly and so consistently in the interest of American Medicine.

(Applause)

But be that as it may, we are losing segment after segment of our practice to government or some other third party: and of course no denying that government is the largest purveyor of medical care in the country.

We now have the Foran Bill which was sponsored by the CIO-AF of L. Mr. Meany makes no bones about it. And, as I say, it's my pet peeve. It's just an indication of what is going on and it is another large segment of our practice which we are very likely soon to lose. If not the Foran Bill, it will be something worse, and there are many worse in already, one by Mr. Humphries and several others of similar type. Let me read a letter that went out to 200,000 doctors. Every doctor in this room got one. I wish I could say he read it. I'm going to read it to the women and then you tell your husbands about it. I sometimes think that doctors can't read.

Here is the letter which sums up, I think, pretty well in my opinion at least of this Foran Bill. I say: "Dear Doctor: There is a bill now in Congress to place the health care of the aged and other OASI plans under government supervision. The Foran Bill, which is HR 467, would provide government hospital and medical care for about thirteen million Social Security claimants by amending the Social Security Act. And as I've told you, the AF of L-CIO sponsored this bill and they are pushing it to get top priority. I'm very fearful that hearings will be held on this Foran Bill sometime within the next two or three weeks, at which time you will be confronted by solid opposition or support of the bill. We'll have the opposition; the bill will have the support of all labor leaders.

"Now, this Foran Bill, in my opinion, is not in the public interest and there are several basic reasons why I think it is bad legislation for all Americans." And these are the reasons I gave in this letter:

"Number 1, it will bring the aged under government control and supervise health care. The government would set and enforce the standards of health care under bureaucratic control limiting choice of hospitals and choice of physicians." No question about that. When they get in there, they are going to pay for it. They are going to limit the choice of physicians and they specifically state that in the bill they supply free surgical service but you must be a Fellow of the American College of Surgeons to qualify to receive the payment for the operation. They give no medical care, just surgical.

"Second, it will eventually destroy the private health insurance and the Blue Shield and the Blue Cross Plans." No question about that. My two co-panelists know that. As Mr. Everett said, this bill in Canada is going to do away with the health insurance industry. That's all there is to it. And, ladies and gentlemen, that is one of our finest and best and biggest free enterprise systems in the country.

"Third, we will have introduced into our economy a permanent basis of wage fixing and of price fixing by government." Again Mr. Everett said there will be no question about what you are going to get. The government is going to tell you what you are going to get. It is a national compulsory health insurance program for a segment of our population; that is, approximately thirteen million who are covered by OASI. And ultimately,

of course, as history shows, when this is done for one segment of the American public it soon spreads to others. When HR-755 was up for consideration, I testified before Congress that if they put the age limit at 65 for men and 62 for women, the next Congress would lower that age limit. That's exactly what happened. That's exactly what will happen here. Either the group will be enlarged or the benefits will be increased at government expense, and government expense means at your expense. It is an attempt to solve a complicated health problem: that is, the care of our senior citizens. It is an attempt to solve this problem by political means rather than through established medical resources. It is making the aged wards of the government with health care hand-outs which we do not feel is a proper way to take care of our older people. We don't want them to receive a certain amount of money from the government or that certain government care be legislated into pure numbers. Every person over 65 feels just as important as you people 35 or 40. They are all individuals with their own personality and their own likes and dislikes and their own wants and they don't want to be segmentized into any hospital and regimented. They have led useful lives and they still have a lot of usefulness left in all probability. We certainly owe it to them to take care of them as individuals and not relegate them to the ranks of paupers or those who receive hand-outs at government expense.

Now, of course, what the legislators do not tell us is that it would mean higher taxes and less take-home pay for all wage earners for the benefit of a very small minority of our population, twelve to thirteen million people. They don't tell you that, but again you heard Mr. Everett say how catastrophic these increased costs can become and they have bankrupted, as he says, several nations and can very readily do it to this country even though we are reportedly the richest country in the world. As a matter of fact, it could bankrupt the entire Social Security program and jeopardize the basic retirement income for millions of Americans: the annuity policies you have. They can so devaluate the dollar that the insurance you bought and paid for with valuable, hard-earned dollars won't be enough to keep you alive under these plans.

You've got to be alerted to these things. You must more than be alerted; you must do something about them. Mr. Everett said that the apathy of the public is terrific. The apathy of you doctors is terrific, too, if I may have the temerity to say so.

This is a damned important thing, ladies and gentlemen, and I mean it just that way. Unless we get out and fight, we are going to lose all our practice. They are nibbling away at it piece by piece. They found out they couldn't do this to us because of the strong fight we put up. The people just were smart enough not to buy the whole hog, so then they adopted the divide and conquer policy and that's what they are doing. They are nibbling away, as I said before, segment by segment until soon we will have no practice left.

Now, it's all right to have the government do some things for some people under certain restrictions. But it isn't all right to ask the government to do everything for everybody as far as medical care is concerned. Our Congressmen and our Senators aren't particularly interested in the quality of medical care, although they say they are. They must know, as we all know, that all these things will do is to increase the *quantity* of medical care probably, but decrease the *quality* of it. It will provide medical care of a mediocre quality for all people, and it will provide good medicine for nobody. And we particularly here in New Jersey have prided ourselves on the excellent quality of our medical care. Should we ever get snafooed into any of these deals, that quality of medical care cannot be maintained.

We must revert to our old spirit of individual initiative and incentive and not succumb to the apparent desire of so many people today to get rather than to give. There are too many people in this country now who are anxious to ride and too few anxious to help pull or push the wagon. We've got to get out of that rut.

These changing socio-economic conditions have brought a great change in our thinking. We no longer are the strong country that our forefathers founded on individual initiative and individual incentive. We are too willing to let George do it for us. And, ladies and gentlemen, it isn't going to pay off in the long run. When George starts to do too many things for us, we are not going to have anything left to do for ourselves.

And don't think that the government can give us everything we want. Well, they probably can give us anything we want, but don't ever put ourselves in that position because always remember that any government that is big enough to give you everything you want is big enough to take away everything you've got.

(Applause)

Dr. Featherston: Thank you very much, Dr. Allman.

Now, ladies and gentlemen, I'm sure that you will agree with me that we have heard from four very talented and very brilliant gentlemen the backgrounds of four of the departments of medical care—achievement and challenge.

While the questions are coming up, Mr. Everett, would you like to expand any part of your subject?

Mr. Everett: Well, Dr. Allman brought up a point that I think is a very serious one. Dr. Borsher touched upon it by saying that the Blue Shield had 7 per cent of the people over 65 in Jersey and Blue Cross 9 per cent. Everywhere that we see this legislative pressure hit, it's always pushed at that particular area of the population. There is nothing magic about the age 65 and so they have said to the insurance industry: Why don't you take care of this group and then we wouldn't have a problem. A gentlemen mentioned to me yesterday that the incidence of sickness is higher at that point. If they are sick and they have no money it can't be insurance; so that you get a compounded felony. We might stop some of the pressure if there were some way to segment the present aged indigent who are problems. Perhaps through some social mechanism, preferably at the local or county level, we could take care of them under some system of grants-in-aid, if you like, so that that is centered. Then let every insurance mechanism go to work to take care of those who are approaching the age of 65 when they can afford to pay for it as working people. That would probably stop a good deal of this legislative pressure.

Dr. Featherston: Dr. Borsher, do you have any ideas percentage-wise—I'm just using a figure which may or may not be within accurate limits, but the number of people in New Jersey who become hospitalized that are covered by the Blue Shield-Blue Cross Plan? You gave us the number of people, subscribers. Do you have any hospital figures yourself? Do you know what proportion of the hospital population at the present time is covered by Blue Shield-Blue Cross?

Dr. Borsher: Out of every hundred persons covered by Blue Cross, within a year 14 possibly 15 of those hundred are hospitalized. That figure probably has increased by about 10 per cent since there has been an expansion of coverage in the out-patient department of the hospital; but essentially 14 out of every hundred persons annually are hospitalized as a bed patient in a hospital.

Dr. Featherston: I understand that about 40 per cent of our hospital population in Monmouth County is covered by some type of Blue Cross-Blue Shield Plan at this time. Maybe that's why we hospital administrators aren't as angelic as we should be to some of our problems.

General, this is probably not a fair question, but somebody asked it and I'll give it to you.

"I have on good authority that the aged aunt of a serviceman in Fort Monmouth has been in the hospital for two years after an accident. If this service is limited to wives and children, how does she qualify?"

General Robinson: Is this in a service hospital?

Dr. Featherston: Yes, sir, at Fort Monmouth.

General Robinson: Well, in service hospitals the program is not limited to wives and children. It's only in the civilian program that it is limited to wives and children.

Dr. Featherston: Would her dependency have anything to do with it?

General Robinson: Yes, in service hospitals but not in civilian hospitals.

Dr. Featherston: When they said Fort Monmouth, I presume they meant at a service hospital. Thank you. Some one asks: Why should a cardiac patient be penalized in that hospital and charged $10 for each electrocardiogram?

Dr. Altschul (Long Branch): Something I've been fighting for three years. Why should a cardiac patient with a myocardial infarction be jeopardized or be put on the spot and have to pay for electrocardiograms at least four or five he has to have in the course of six weeks in the hospital admission, when he is admitted with a diagnosis of myocardial infarction? Now, the patient that is admitted with a diagnosis of duodenal ulcer and has an x-ray examination is not charged for the examination or the interpretation of the GI series. Why should a cardiac patient be penalized?

Dr. Borsher: The coverage by Blue Cross is comprehensive coverage under its current contract. All services in a contracting hospital of Blue Cross—and there are over 250 contracting hospitals in the metropolitan area—all services including electrocardiograms are service benefits and paid in full under semi-private and ward care and also under private room care. The only thing a patient with Blue Cross coverage has to pay in a contracting hospital, outside of incidental expenses for telephone and so forth, is the difference between

the highest rate for a semi-private room and the private room charge.

DR. ALTSCHUL: In other words, am I to understand that it's up to the hospital, not Blue Cross, to straighten these things out? Because I think it's unfair for a patient with a myocardial infarction to be charged $40 for four cardiograms.

DR. BORSHER: Was this charge that you are referring to made for hospital services or for the physician's?

DR. ALTSCHUL: He is in the hospital, has four cardiograms, he is charged $10 apiece; and another patient who comes in with a duodenal ulcer and has a GI series is not charged at all.

DR. BORSHER: The hospital services under the Blue Cross contract are covered in full in a contracting hospital.

DR. ALTSCHUL: The answer that I have been given by the administrator of the hospital has been that the thing has been paid for by the patient. Well, I don't think it's fair because when a GI series is done, the interpretation of the x-ray man goes along with the x-ray service. So I don't see why they should make any exception for a cardiac patient. Now, if this is a question of individual hospitals, I'm willing to fight this out with my own hospital. But I have been told that this is a rule that goes beyond the hospital. Now, I'd like to have that clarified, if I may, sir.

DR. BORSHER: If that is a contracting hospital with Blue Cross, then the service coverage is complete except for the difference between the semi-private and private room rate.

DR. FEATHERSTON: The problem still goes back to the hospital. Now this is for you, Dr. Allman. "What may the women do to assist in defeating the Foran Bill?"

DR. ALLMAN: Well, the first thing the women can do is to acquaint their husbands, if they do not already know, of the dangers attendant thereto. The second thing they could do is to discuss with their friends at their social functions the inherent dangers of this bill. Instead of actually taking care of our senior citizens in the way they are entitled to be taken care of, they will be relegated to the ranks of the pauper. We might say, that where they accept government handouts and get this government care free of charge, they will also receive impersonal service. They will receive a lower quality of service. They will be deprived of their choice of physician in many cases.

The women can do just exactly what they did when we fought the Murray-Wagner-Dingell Bill and their efforts at that time were very satisfactory.

The AMA has published a pamphlet which goes into some detail as to what can be done and what should be done, and if any of you women write to the AMA or write to me I'll see that you are supplied with it.

It is an educational process that we must go through the same as we went through in 1949 and 1950, telling the people of all the dire results which would eventually occur if legislation of this type passes.

I briefly mentioned to you in my short talk about seven of those things: Lowering the quality of medical care, about increasing the cost of taxes. If the husband of the woman you are talking to is a wage-earner, you can impress upon her that he will have much more taxes taken out of his pay and therefore have less take-home pay. And many other things in addition to the seven items I listed.

We have a pamphlet describing the whole thing in detail, which I will be very happy to submit to you. The basic point is that it's not the American way. It's expecting big government to do things for us that we should be doing ourselves.

DR. FEATHERSTON: Mr. Everett, do you have a question there?

MR. EVERETT: "Is it possible that in the future companies will divide coverage costs so that there will not be an overlap, as fire insurance companies now do?"

I presume that this particular question is raised on the basis of people having several policies and thereby are able to make a profit on illness. Insurance companies do not like over-insurance any more than you do. But we have some very interesting commissioners of insurance in the United States who have always felt it's the right of a person to contract, and so if they want to buy so many potatoes they should be allowed to do so; and therefore they have opposed our efforts to date to put restrictions into regulation which are necessary to keep people from having duplicate coverages. This is going to happen and we are ultimately going to be able to do as the fire companies have done. You have a stated value on the property; you don't have a stated value on illness; but we will ultimately in the next few years, I'm sure, succeed in getting the commissioners to recognize that this is not a sensible position. Duplication of coverage results in loss.

DR. FEATHERSTON: Dr. Borsher, what is the actual need for increased income level contracts? What are the numbers so far that this will bring to the groups?

Dr. Borsher: The present income limit for an individual is $5000; for a family it's $7500. As far as income limit service benefits is concerned, this affects between 75 and 80 per cent of the population and affords service benefits to the same number of subscribers who in 1949 were covered under the $5000 income limit of the subscriber. The present income limit approach appears to be a satisfactory one. From the viewpoint of the public there is tangible evidence that the medical profession through the Medical Society is attempting to cooperate with, develop and sponsor an adequate program of service coverage.

Dr. Featherston: I would think that this meant what is the actual need for the increased level up to the income of $10,000 which I understand is contemplated.

Dr. Borsher: I believe that any discussion of a higher income limit was purely on the basis of determining insofar as the future is concerned as to whether the plan could, with the approval of the Department of Banking and Insurance, contemplate at any time in the future a two-level contract insofar as the scheduled payments are concerned. Up to the present time the plan has not been permitted to contemplate having two levels of payment for the same service.

Dr. Featherston: Mr. Everett, "What are private insurance companies doing or planning for the chronic illnesses of the aged?"

Mr. Everett: There is extensive research going on and we are working with the American Medical Association, and the American Hospital Association in an attempt to get the right definition for this type of person and to find out if there is an insurable area; and if not, to find the type of mechanism that can take care of it and then insure the younger folks moving to the level.

Dr. Featherston: "Do any medical societies have their own retirement plans? If not, why not?"

Dr. Allman: I don't know about retirement plans. Some of them do have death benefit plans or disability plans. If a physician becomes disabled or if he dies, his widow or family are taken care of. Some societies do have that. Other societies have what New Jersey has: the Society for Widows and Orphans of Medical Men of New Jersey, which is in the nature of an insurance plan, where a widow or a widow and orphans receive some money from the society.

If I may just interject here and follow through on the question just asked Mr. Everett where he said he was working with the American Medical Association—of course it's true. In contradistinction of the Foran Bill which just takes these 13 to 14 million people over 65 out of thin air and wants to take care of them without any regard as to how many of that number first have insurance that is adequate; second, how many have families willing to take care of them; and third, how many are able to take care of themselves. The Foran Bill has made no study of that and knows nothing about it.

Three months ago there was set up in Chicago the Joint Council for the Improvement for the Care of the Aged. This joint council consists of four groups: The American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Homes Association. These four groups are making an analysis of the needs of the senior citizens. We are calling upon, the same as they are calling upon us, the insurance industry and all others to correlate our facts and figures and find out just what the need is in this area and, after knowing the need, to arrive at a scientific approach to the problem, as Mr. Everett has indicated, rather than as the Foran Bill goes, just take care of everybody covered by OASI. We are going to find out how many of this 13 million actually want or need such coverage and then in conjunction with these four groups working together with the insurance industry and others we hope to come up with some sensible solution rather than some political hand-out for them.

Dr. Featherston: Here is someone who wants to know, Dr. Borsher: "Why not knock the small nuisance claims out of the Medical-Surgical Plan; that is, like out-patient emergencies?"

Dr. Borsher: You mean by a deductible approach?

Dr. Featherston: He doesn't say. Just said, why not knock out the small nuisance claims, maybe saving expenditures for the great number of small claims that undoubtedly are being submitted.

Dr. Borsher: The coverage of services outside of hospital is limited to emergency services in connection with accidental injury and tonsillectomy in the office, plus obstetric services. The demand now is for expansion of coverage outside of hospital. These are not nuisance claims. These services must be rendered.

Looking at it from the viewpoint of nuisance claims, a patient does not want to go to a doctor unless he has to. People should be encouraged to apply for early diagnosis and

treatment rather than to put any blocks of any sort, including deductibles, in their way.

DR. FEATHERSTON: The tendency is definitely toward expanding the services of the contract, therefore making it more attractive. Getting into sales now.

"What is the recently proposed program for the AMA to supersede and counteract the Foran Bill for taking care of the old age chronically ill patients?"

DR. ALLMAN: I think I probably answered that by telling about the Joint Council. We are trying to find some place that they can go when we find out just what the needs are, where the costs per day will not be as much as in an active hospital and where the services they will receive will be a little better than the average present nursing home. There is a place in between the nursing home and the hospital where these people can receive adequate medical attention when they need it: a nursing home of a little higher standard. That's the reason I say one of the groups in here is the American Nursing Homes Association.

DR. FEATHERSTON: Dr. Borsher: "How do you reconcile the basic tenet of Blue Shield—a standardized fee set by Blue Shield—against the basic tenet of a physician's fee for service rendered; in other words, the inherent right of a physician to evaluate his own services?"

DR. BORSHER: There is a misconception about the Blue Shield Plan fixing a fee. This schedule of payments has been arrived at with respect to an income limit that applies to a majority of the population in order to arrive at a reasonable cost premium-wise to a large section of the community. A plan, either Blue Cross or Blue Shield, really serves as a community approach. These fees are not fixed permanently. Over the years there have been changes in the levels of the schedule of payments. This schedule of payments has been arrived at only following consultation with the representative groups of the Medical Society. These conferences have been held over the years and are still continuing. Hardly a six-month period goes by when there are not considerable changes in the schedule of payments: not changes across-the-board, but changes in payment for individual procedures.

DR. FEATHERSTON: Thank you very much, sir.

We have about approached the limit of our estimated time, and I wish at this time on behalf of The Medical Society of New Jersey to thank you gentlemen for your time and effort. We have been honored and it has been a pleasure to have you.

Thank you very much, ladies and gentlemen, for your attendance.

New Honor for Dr. Allman

Our own (and the A.M.A.'s) Dr. David B. Allman added another honorary degree to his collection on June 15 when Temple University presented him with an honorary D.Sc. degree. In making the citation, Dean William N. Parkinson described Dr. Allman as:

"A public spirited citizen, Dr. Allman served with the U. S. Navy Medical Corps in World War I, and was commissioned in the U. S. Public Health Service during World War II. In the meantime, he found time to participate in numerous civic as well as professional activities—at local, state, and national levels. As a Trustee and Chairman of the Committee on Legislation of the American Medical Association, he has appeared at public hearings many times before Congressional Committees in Washington, D. C.

A surgeon respected by his colleagues, patriotic citizen dedicated to his nation's service, humanitarian and philanthropist, it is a pleasure to present my friend, David Bacharach Allman, for the honorary degree of Doctor of Science."

Obituaries

DR. JOHN F. ANDERSON

One of America's pioneer bacteriologists, Dr. John F. Anderson, died in New Brunswick on September 30, 1958. Dr. John F. Anderson was the discoverer of the causes of both typhus fever and spotted fever. He was the author of more than 150 publications and was generally considered one of the original minds in bacteriology.

Dr. Anderson was born in Virginia in 1873 and was graduated from the University of Virginia in 1895. In 1898 he became an assistant surgeon of the Public Health Service where he did his work in epidemiology. He served all over the world in this capacity.

Later he became director of research for Squibb and was also active in civic affairs in the New Brunswick area. He was chairman of the board of the New Brunswick Savings Institution and a trustee of the New Brunswick Chamber of Commerce at the time of his death. He was an emeritus member of the Middlesex County Medical Society.

DR. EDWARD A. FLYNN

One of Essex County's best known physicians, Dr. Edward A. Flynn, died on September 28 as a result of injuries sustained in an automobile accident on September 19. Born in Buffalo, New York, in 1892, Dr. Flynn was graduated in 1915 from the medical school of the University of Vermont. He interned at New York's St. Vincent Hospital and then joined the army as a medical officer. He served first as a battalion surgeon and later as commanding officer of a hospital company, seeing service at Argonne and St. Mihiel.

On being mustered out, Dr. Flynn came to New Jersey, first as a general practitioner in Jersey City. A few years later he moved to Belleville and he served the people of Belleville from 1921 to 1958. A former president of the Essex Physician's Club, he was an amateur poet of state-wide reputation in literary circles as well as an amateur gardener of considerable distinction.

DR. HORACE B. LODER

On September 14, Dr. Horace B. Loder, the well-known south Jersey internist, died at the hospital where he was a member of the medical staff: The Bridgeton Hospital. Dr. Loder was born in Bridgeton in 1903 and was graduated in 1928 from the medical school at Johns Hopkins. After a brief period of practice in Vermont, he returned to his native Cumberland County and served the people of that area from 1931 until his death in 1958. Dr. Loder was the first medical director of the local Community Nursing Service and a vestryman at the St. Andrew's Episcopal Church. He served in World War II as a major in the medical corps.

DR. WILLIAM G. SHEMELY

An emeritus member of the Camden County Medical Society, Dr. William G. Shemely died in Philadelphia on September 18. A native of Camden, Dr. Shemely was graduated in 1910 from Hahnemann Medical College. He interned at the West Jersey Hospital, and then did general practice in Philadelphia. Dr. Shemely became increasingly interested in ophthalmology and otolaryngology and in 1933 returned to Camden and limited his practice to that specialty. The following year he won board certification in otolaryngology. He was also a Fellow of the American Academy of Ophthalmology. Dr. Shemely was 70 years old at the time of his death.

DR. HIRAM WILLIAMS

Passaic County lost one of its best-known physicians on September 4 with the death on that day of Dr. Hiram Williams. Dr. Williams was born in Maine during the presidency of Andrew Johnson. In 1896 he earned his M.D. at Bellevue and a few years later he crossed the Hudson to New Jersey and opened an office in the city of Passaic. He served the people of the area for a full sixty years. At one time he was the town's Health Officer. He was a senior examiner for the Prudential. For decades, he was chief of surgery at the Passaic General Hospital. He was an emeritus member of the Passaic County Medical Society and the laureate of a special dinner-meeting held in his honor in 1957. He was active in civic affairs and had several terms on the Board of Education. Dr. Williams was the chief spirit in the move to construct the Paulison Avenue Isolation Hospital in Passaic, and he lived to see communicable disease so well controlled that he could rejoice when the structure was converted into a day nursery.

Announcements • • •

Unusual Tumor Seminar

The Annual Slide Seminar on Unusual Tumors, sponsored by the New Jersey Society of Pathologists and the New Jersey State Department of Health, will be held on Saturday, December 6, 1958, at the Essex House in Newark, beginning at 2 p.m. Dr. Arthur Purdy Stout of Columbia University will be the moderator. Jacob Churg, M.D., of Paterson, is Chairman of the Program Committee. The New Jersey Department of Health is represented by E. L. Shaffer, Ph.D., Director of Laboratories. Case histories and micro slides prepared in the Bureau of Pathology are being mailed to all members of the Society. You are invited to attend.

PMR Essay Contest

To stimulate interest in physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation awards a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest is directed to interns, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation. The following regulations apply to the contest:

1. Any subject of interest to physical medicine and rehabilitation may be submitted.

2. Manuscripts must be in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, not later than March 2, 1959.

3. Contributions will be accepted from interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.

4. The essay must not have been published previously.

5. The American Congress of Physical Medicine and Rehabilitation will have the exclusive right to publish the winning essay.

6. Manuscripts must not exceed 3000 words (exclusive of headings, references, legends for cuts, and tables) and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.

7. The winner will receive a cash award of $200.

The winner will be determined by the Essay Award Committee composed of four members of the American Congress of Physical Medicine and Rehabilitation. However, the Congress of Physical Medicine and Rehabilitation reserves the right to make no award if, in the judgment of the Committee, no contribution is acceptable.

Graduate Courses in New York

ALLERGIC DISEASES
Full time, December 1 through 19, 1958.
PEDIATRIC CARDIOLOGY
Full time, December 1 through 5, 1958.
LARYNGOLOGY AND SURGERY OF LARYNX AND NECK
Full time, January 5 through 16, 1959.
PERIPHERAL NERVE INJURIES
Full time, January 8 and 9, 1959.
APPLICATION OF BASIC PHYSIOLOGY TO DIAGNOSIS OR THERAPY
Full time, 7:30 to 9:30 p.m., Thursdays, January 8 through February 26, 1959.
REGIONAL ANESTHESIOLOGY
Full time, January 12 through 17, 1959.
ANATOMY FOR ORTHOPEDISTS
Full time, January 12 through 16, 1959.
BASIC UROLOGY
Full time, January 12 through 16, 1959.

For additional information write to the Associate Dean at the Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Intestinal Obstruction of the Newborn

On November 21 at the Babies' Hospital (Coit Memorial) at 17 Roseville Avenue, Newark, there will be a symposium on intestinal obstruction of the newborn. The guest lecturer will be Dr. John Caffey, Attending Pediatrician at the Presbyterian Hospital in New York City. The program starts promptly at 11:30 a.m. on Friday, November 21. All readers of this JOURNAL *are invited*. The meeting will be in the Nurses' Home.

Reclamation of Human Resources

The Seventh Annual Fred H. Albee Memorial Lecture will be held at the Kessler Institute for Rehabilitation in West Orange on Saturday afternoon, December 13, at 2 p.m. The speaker is the Surgeon General of the United States Public Health Service. His topic is "Medicine's Unfinished Business: Reclamation of Human Resources."

All physicians, nurses and rehabilitation personnel are welcome to attend this inspiring address. There is no charge.

The Kessler Institute is on the west side of Pleasant Valley Way between Mount Pleasant Avenue and Northfield Avenue in West Orange.

Honor for a Woman Doctor?

Do you know of a woman doctor in New Jersey who has made substantial contributions to Child Welfare? If the doctor is under age 40, please send her name to the Executive Officer of The Medical Society of New Jersey at P.O. Box 904, Trenton 5, New Jersey. Say you are entering the name for the Spence-Chapin award. This non-sectarian, interracial adoption agency has been serving children for half a century and wants to honor the women doctors of the metropolitan area. In your letter, indicate in what way the doctor has made this contribution to the welfare of children.

Diagnostic Hospitalization and Blue Cross

Physicians sometimes ask about the conditions under which diagnostic services are eligible under the New Jersey Hospital Service Plan. As a general rule, diagnostic services are *not* eligible. See V-3 of the Subscription Contract. The Plan uses the following definitions:

1. A diagnostic study is an x-ray, laboratory, endoscopic or surgical procedure performed for diagnosis, evaluation, confirmation (or to rule out) or to check the progress of a previously diagnosed and/or treated condition.

2. An endoscopic or surgical procedure performed primarily as a diagnostic study is a diagnostic study even though some therapeutic effect may be obtained, for example, non-surgical endoscopies including laryngoscopy, bronchoscopy, esophagoscopy, gastroscopy, cystoscopy, sigmoidoscopy, proctoscopy; also salpingography and any other procedure performed through natural body orifice.

3. A mandatory diagnostic study is a procedure that is required to be done for all patients in the hospital in accordance with *written rules and regulations* of the hospital governing body, as for example, urine or blood chemistry.

4. A hospitalization primarily for diagnostic studies is a period of hospitalization during which although some treatment may be given, the hospital facilities are utilized primarily to perform diagnostic studies.

Hospitalization primarily for diagnostic studies as defined above is not eligible for Plan payment.

Exception: Hospitalization for the following inclusive list of surgical procedures *is eligible* for Plan payment provided no other diagnostic studies are performed (mandatory studies excluded) during the hospital stay and the hospital stay is not prolonged beyond the time ordinarily needed for the postoperative care for such diagnostic surgical procedure:

a. Angiocardiography
b. Arthrogram
c. Cardiac catheterization
d. Cerebral arteriography
e. Lumbar aortography
f. Myelography
g. Peritoneoscopy
h. Pneumoencephalography
i. Thoracic aortography
j. Thoracoscopy
k. Ventriculography

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society*, September 9, at Bergen Pines Hospital, Paramus, was called to order by George Heller, M.D., President.

The President expressed gratification at the number of questionnaires returned by members, indicating their willingness to serve on committees for the coming year. He stated that committee personnel had been made up in accordance with both the expressed wishes of the members and consideration to continuity of policy and geographic distribution.

The Chair announced the appointment of Dr. Thomas DeCecio as parliamentarian for the coming year with Dr. Robert E. Verdon as alternate parliamentarian.

The Secretary asked members who were elected at the June meeting to take a bow as their names were read.

The Secretary displayed the 1958 *Directory and Roster* and complimented the Publications Committee on this new format and accuracy. Accuracy seemed confirmed by the fact that there have been only two calls for minor corrections since its distribution to the membership in August.

The Secretary read a resolution memorializing Dr. Alfred T. V. Brennan, Jr., deceased. This was unanimously passed.

The Secretary read the annual report of the Pharmaceutical Committee. Dr. Charles F. Post is Chairman of this committee.

Dr. J. P. O'Connor announced that 19 members were in arrears on Blue Cross premiums and that those who were in arrears as of October 1, would be dropped from the group and placed on an individual subscriber basis.

The Chair introduced Dr. William J. Roe, Chairman of the Scientific Program Commitee, who presented Dr. Emerson Day, Director, Strang Cancer Detection Clinic. Dr. Day delivered a very interesting and challenging discussion on the methods of early cancer detection that can be carried out in the office of the medical practitioner. He emphasized that the forty-five minute, three part examination was *not* a prerogative of the specialist but should be performed by any medical practitioner in his day to day practice. The three parts of the study are: (1) history, (2) physical examination, and (3) laboratory and x-ray. The two procedures which produced the highest yield in positive carcinomas were the Papanicolaou technic and proctosigmoidoscopy.

At the conclusion of his remarks, Dr. Day was warmly applauded and the appreciation of the Society was expressed to him by the President.

There being no further business, the meeting was adjourned to collation at 10:12 p.m.

CHARLES P. CAMPBELL, M.D.
Reporter

Camden

The first meeting of the 1958-59 season of the *Camden County Medical Society* was held on October 7, in the auditorium with the President, Eric A. Denbo, M.D., presiding.

George W. Anderson, M.D., was introduced to the Society upon taking the oath of membership and signing the register. Drs. Raymond A. Davis and August S. Rivero were elected to membership.

The guest speaker, Dr. Henry J. Tumen, Professor of Clinical Gastro-enterology, Graduate School of Medicine, University of Pennsylvania, discussed the "Diagnosis and Treatment of Ulcerative Colitis."

Memoirs for the following were presented: George R. Kennedy, M.D., prepared by Dr. Schull; Alexander Ellis, M.D., prepared by Drs. Frantz and Kutner; Dr. John W. Fessman prepared by Dr. Tatem, and Dr. Alexander Sochacki, prepared by Dr. Kutner.

Dr. A. G. Pratt, chairman of the Long-Term Planning Committee, reviewed for the membership the proposed changes in the Constitution and By-Laws as read at the May meeting. The proposed changes were passed.

Dr. Frederick W. Durham, reporting for the Executive Committee, advised the membership of the matters presented in the Committee Meeting and discussed possible meeting arrangements. It was agreed that the next meeting would be held in the Society Building on January 6, 1959.

Dr. I. Edward Ornaf, reporting for the Nominating Committee, proposed the following candidates for the following offices: Dr. George Grenhart to fill the one year unexpired term on the Executive Committee, he was duly elected; Alternate to the State Convention, Dr. August Ciell, who was duly elected. New members proposed for the Executive Committee were Dr. G. Frank Santor, for one year; Dr. Harold P. Coxon, for two years; Dr. S. Thomas Carter, for three years; these men were duly elected.

The meeting adjourned at 11:40 p.m. There were 90 members present.

EUGENE H. KAIN, M.D.
Reporter

Cape May

The *Cape May County Medical Society* held its first autumnal dinner meeting at Zaberer's on September 30. Attendance was fair. The guest speaker of the evening was Dr. K. B. Conger, of the urology department at Temple University Hospital, Philadelphia. Dr. Conger presented an illustrated lecture entitled, "Urological Obstructions in Children." At the business meeting, Dr. John A. Moir, of Cape May Court House, was appointed

the new county chairman for the diabetes program. The position was formerly held by Dr. William Doebele of Ocean City.

Dr. Robert Stineman reported for the Radio Committee. He announced that a series of recorded lectures on heart disease would be broadcast over Radio Station WCMC each Wednesday night at 8:45 p.m.

Dr. Stineman was also appointed as our representative to the Water Conservation Group for New Jersey.

SAMUEL J. MAZZOTTA, M.D.
President

Gloucester

The first meeting of the new year was attended by 24 members. It was held on September 18 at the Woodbury Country Club.

The speaker was Robert Carroll, M.D., Director of the Blood Bank at Jefferson Hospital. His subject was "Leukemia." Dr. Carroll reported evidence that leukemia is not transmissible through transfusions. He discussed transplants of bone marrow.

At the business meeting it was decided that the gift for the Albert Barker Kump Memorial Grant should not take the place of individual contributions.

It was voted to increase dues by $5, making a total of $85 for which the treasurer promised prompt billing.

DOROTHY M. ROGERS, M.D.
Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on October 7. Dr. John J. Bedrick presided.

Guest speaker for the evening was Dr. Philip H. Henneman, Director of the Division of Endocrinology and Metabolism at the Seton Hall College of Medicine and Dentistry. The subject of Dr. Henneman's presentation was "Metabolic Aspects of Renal Stones." Many doctors participated in a discussion from the floor.

Dr. Louis Kosminsky reported on a recent meeting of the Welfare Committee of The Medical Society of New Jersey. There was also a discussion of the difficulties physicians are having with their malpractice insurance coverage. The Society voted to initiate a Blue Shield plan for the members.

Elected to active membership were Drs. Maimu Bogart, Robert B. Edelmann, Harold Lakin, George Lamzaky, Jay Philip Sand, James E. Thompson and Alfonso J. Teresi of Jersey City, Dr. Harold Rosenzweig of Bayonne.

CLEMENT M. JONES, M.D.
Reporter

Monmouth

Fitkin Hospital, with its new Ford Auditorium, was host to the *Monmouth County Medical Society* at its regular meeting on September 24, with Dr. David McCreight presiding.

The following were elected to full membership: Drs. Elizabeth Ann Dawson, and Richard H. Small by transfer from Passaic County. Associate membership was granted to Drs. Martin Alperin, Harold Chafkin and William A. Kaloss, all of Middletown, and Gilbert Meltsner, Oakhurst.

The scientific session featured a discussion by Dr. Joseph E. Campbell, Forensic Pathologist to and Deputy Medical Examiner of Philadelphia. His subject was "Evaluation of Deaths Associated with Operative and Anesthetic Procedures."

DONALD W. BOWNE, M.D.
Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held September 16 at 9:00 p.m. at the Medical Society Building. The President, Dr. Theodore K. Graham, presided.

Elected to membership were: Drs. Stephen P. Ferraro, Peter A. Tucci, Andrew Sporer, Eugene Gottlieb of Paterson, John R. Fenwick of Totowa Borough and Paul D. Murphy of Pompton Plains; Associate members elected were: Frank M. Ash, Paterson; Herbert B. J. Gong, Haskell; Ben Sheiner, Belleville; Sidney B. Shane, Wayne; Thomas F. Shivy, Pompton Plains; Ralph M. Talucci, Midland Park.

The President explained the change, this year, for presenting the annual report of the Finance Committee with its recommendations during the September instead of the October meeting. This is due to the latter being our Installation Meeting, at which the business session is kept to a minimum. Since there were no objections, the Chairman of the Finance Committee, Dr. Frank B. Vanderbeek, submitted the report of his committee for the fiscal year ending May 31, 1958, with its recommendations concerning the amount of dues for 1959. The report and recommendations of the Finance Committee were approved as presented. The October issue of the *Bulletin* reprinted the complete report.

Dr. Graham asked Dr. Keating to inform the

members of the Graduate courses offered. Dr. Keating stated that the Department of Graduate Medical Education of Seton Hall College of Medicine and Dentistry has prepared a series of excellent lectures, three of which shall be given in local hospitals. The members were urged to avail themselves of these lectures, a list of which appeared in the October *Bulletin*.

The President called upon Dr. Abraham Shulman to read the Resolution on the death of Dr. Morris S. Joelson. The Resolution was adopted as read.

Dr. Graham then turned the meeting over to Dr. Irving Chrisman who introduced the speaker, Robert A. Cosgrove, M.D., Attending Obstetrician at the Margaret Hague Maternity Hospital. Dr. Cosgrove's subject was "Rupture of the Pregnant Uterus." The discussors were Drs. Leopold E. Thron and Paul Grossbard.

Dr. Julian Cohen, Chairman of the Installation Dinner, urged all members to attend the Annual Meeting. He expected a well-attended meeting as there were no holidays or outstanding conferences at the time to prevent the members from coming.

Refreshments were served at the conclusion of the meeting.

DAVID B. LEVINE, M.D.
Reporter

Salem

The *Salem County Medical Society* opened its 1958-59 program on September 19 with a business meeting at the DuPont-Penns Grove Country Club. Dr. Charles E. Gilpatrick presided. Dr. Wilbert Staub was appointed alternate delegate to The Medical Society of New Jersey and Dr. Dorson Mills as member of the Welfare Committee of our State Society.

Dr. John Madara spoke of the activity of the Subcommittee on Legislation of the State Society's Welfare Committee. He discussed pending legislation on state and national levels. Dr. W. L. Sprout reviewed the program for the Eye Health Screening Clinics to be held at the Salem County Memorial Hospital. Dr. George Nitsche outlined the programs of the Society meetings for the coming year.

Dr. I. Lipkin again accepted the chairmanship of the County Diabetes Detection Program for this year and was assured of continued cooperation by the members.

Society approval was received by Dr. Harry Suter for the proposed Diet Clinic to be held under the sponsorship of the Salem County Heart Association. This clinic will be held in November and will feature preparation of various diets including low sodium intake with emphasis on palatability.

G. F. REICHWEIN, M.D.
Reporter

Union

Under the chairmanship of Dr. Graham C. Newbury, its president, the *Union County Medical Society* held its regular meeting at White Laboratories, Kenilworth, on September 17.

The secretary, Dr. Charles W. Boozan, read memorial resolutions on the deaths of Dr. Joseph A. Novello and Dr. Pasquale Cardinale.

Dr. Truman D. Boyes of Plainfield was elected as an Associate member and Dr. Max Mendelson of Elizabeth a Regular member. The following were accepted for membership as transfers from other counties: Dr. Frederick Ambrose of Elizabeth from the Somerset County Medical Society; Dr. Milton D. Fox of Elizabeth from the Essex County Medical Society; Dr. Sidney Ketyer of Elizabeth from the Queens County Medical Society of New York; Dr. Maximillian Schoss of Roselle from the Essex County Medical Society; and Dr. Heinz J. Wittig of Cranford from the Monroe County Medical Society of New York.

Following the business meeting, Dr. Elmer P. Weigel of Plainfield, delegate to the American Medical Association, gave a report on the 1958 A.M.A. Convention. Dr. Weigel's interesting report covered the activities of the House of Delegates in detail as well as the convention as a whole and was warmly received.

After adjournment a collation was served.

E. H. POGUE, M.D.
Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Essence of Surgery. By C. Stuart Welch, M.D. and Samuel R. Powers, Jr., M.D. Philadelphia 1958, Saunders. Pp. 320, 50 illustrations. ($7.00)

Doctors Welch and Powers present a clear, concise monograph on surgical principles which are obviously the result of many years of preparation. Their work stems from their undergraduate teaching experience in which they have had to provide a framework for learning surgery that is universally useful.

Following an excellent chapter on the history of surgery, they show that surgery is a separate discipline of medicine, which they see as the art and science of taking care of the injured. Under the management of surgical injuries, they discuss the loss of body tissue, loss of body fluids, infection and principles of pre-operative and post-operative care.

Under surgical technic they cover the three essentials of operation: asepsis, hemostasis and dissection. They divide operative surgery into (1) the treatment of the wounds, (2) extirpative surgery, (3) reconstructive surgery, and (4) physiologic surgery. The book concludes with a fine chapter on anesthesia by Dr. Converse, formerly associated with the authors at Albany Medical College.

This book provides interesting reading for all physicians. Surgeons will find it exceptionally informative.

GEORGE F. HEWSON, M.D.

The Extent of Cancer in the United States. U. S. Public Health Service. Government Printing Office, Washington, D. C. 1958. PHS Publication 547. Paper. Pp. 24. ($.25)

For 25 cents every doctor can (and should) get this pamphlet of cancer facts. It points out that cancer is the second cause of death in the United States. Curiously enough, however, if cancer could be entirely eliminated, this would add only 2½ years to average life expectancy. The booklet gives information about the probability of getting cancer, the various sites, urban-rural ratios, age incidence, differences in marital status (single persons have higher cancer death rates than married persons), geographical differences (southern states have higher skin cancer rates than northern states) and life expectancy. The more we know about this grim reaper, the better.

VICTOR HUBERMAN, M.D.

Textbook of Clinical Neurology. By Israel S. Wechsler, M.D. Philadelphia 1958, Saunders. Ed. 8. Pp. 782. ($11.00)

For thirty years, Wechsler has been one of the standard textbooks of neurology. This new—the eighth—edition brings in fresh material on the hypothalamic syndrome, on convulsive disorders and anticonvulsant medication, injury to the nervous system and poliomyelitis. As always, Wechsler writes with simplicity, orderliness and transparency. Like good wine, this needs no added bouquet. Ten thousand physicians, by now, must have used earlier editions of this book as their neurologic text. It has become the old reliable of neurology, and seeing a new edition is welcoming an old friend.

HERBERT BOEHM, M.D.

A Practical Manual on the Medical and Dental Use of X-rays with Control of Radiation Hazards. Published 1958, Chicago, by the American College of Radiology. Pp. 31. Price 25 cents.

Here in brief, highly readable form, is a "must" for anyone engaged in the use of x-rays. Lavish use of diagrammatic illustrations and simple explanatory remarks reduces what is otherwise a technical subject, to readily understood terms. Divided into two major sections, the manual pinpoints radiation hazards and sources and their effect on the body. The second section spells out the safest methods for doing fluoroscopy and all forms of radiography. It should be required reading for anyone using x-ray in any form.

CARL KNITZER, M.D.

TUBERCULOSIS Abstracts

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXXI November, 1958 No. 11

Community Trials of BCG Vaccination

Carroll E. Palmer, M.D., Lawrence W. Shaw, M.D., and George W. Comstock, M.D., The American Review of Tuberculosis and Pulmonary Diseases, June, 1958.

● A progress report on two controlled trials of BCG vaccination shows that persons already infected with the tubercle bacillus are now at greatest risk. In this country the advantages of vaccination are outweighed by the disadvantages.

Introduction. Although BCG was first administered to a human subject in 1921, its use during the next twenty-five years was based largely on results of laboratory studies and clinical experience gained from vaccinating highly exposed children and young adults. In the United States, little interest in BCG developed until the appearance in 1945-46 of reports of three studies which embodied some of the features now considered essential for adequately controlled trials. In two of these studies much less tuberculosis among vaccinated than unvaccinated subjects was reported. Other investigators could find no effect of vaccination on tuberculosis mortality. At about the same time, interest in BCG was stimulated by the rapidly expanding Scandinavian programs which were soon to culminate in the international mass campaigns sponsored by UNICEF and the World Health Organization.

In spite of a growing enthusiasm for BCG, its use remained limited in some countries, including the United States and Great Britain, reflecting the judgment that convincing evidence of its value was still lacking.

Meanwhile in the United States an advisory committee to the Surgeon General of the Public Health Service had expressed the view, in 1946, that the evidence was not sufficient to justify extensive use of BCG in this country and recommended that the Public Health Service undertake controlled trials in different kinds of population. In line with these recommendations, several trials were planned by the Tuberculosis Program of the Public Health Service. They were to be strictly controlled trials, designed to avoid at least some of the deficiencies of earlier studies. A system of allocation was to be used which would ensure the similarity of a vaccinated and an unvaccinated control group, and every precaution would be taken to avoid bias. Tuberculin reactors, although not considered eligible for vaccination, would be included in the study population. By observing the number of new cases of tuberculosis appearing among the reactors, as well as among the vaccinated and controls, it would be possible to determine how much of the total amount of tuberculosis could have been prevented by vaccinating all nonreactors. The follow-up system would utilize medical, public health and vital statistics reporting systems as an economical way to obtain sufficient and at the same time unbiased information on new cases of tuberculosis which develop in the study population. Large numbers of persons living under various conditions would be followed for a sufficient period of time to obtain information on both the immediate and long-range effects of vaccination.

After exploratory studies in 1947 among school children in Muscogee County, Georgia, and patients of mental hospitals in Georgia and Michigan, four controlled trials were undertaken. To test the value of BCG for selected "high-risk" groups, one trial was started among patients of Ohio mental institutions in 1948, and another among American Indian school children in 1949. A third trial was also started in 1949 among children in Puerto Rico; and, to test the usefulness of BCG in a general population in the continental United States, a fourth trial was begun in Muscogee County, Georgia, and Russell County, Alabama. A progress report of the community trials in Puerto Rico and in Muscogee and Russell Counties during the first six to seven years of

follow-up observation is here summarized. (The detailed account of the methods and procedures employed in these trials is omitted because of space requirements. Ed.)

SUMMARY

A progress report has been made after a follow-up period of six to seven years of two controlled trials of BCG vaccination, initiated and directed by the Public Health Service. One trial, on children aged one to eighteen years, is in Puerto Rico, an area where tuberculosis has been a serious problem for many years; the other, on persons more than five years of age, is in the community formed by Muscogee County, Georgia, and Russell County, Alabama, where the tuberculosis problem is similar to that found in many other communities in this country. More than a quarter of a million persons were placed under study: 112,000 tuberculin reactors, and 144,000 nonreactors who were allocated by a randomization scheme to vaccinated and control (unvaccinated) groups. For the identification of new cases of tuberculosis appearing in the study populations, the established medical, public health, and vital statistics reporting systems were deliberately chosen as being sufficient for the purposes of the study, and also as being more likely to yield unbiased information than systematic periodic examinations. Certain policies and techniques were adopted as safeguards against the introduction of bias in the diagnosis and reporting of cases.

The most striking finding of both trials was that the risk of developing tuberculosis was much greater for persons who were tuberculin reactors on entry than for those who were nonreactors. Of the total number of cases that appeared during the follow-up period, 75 per cent were among reactors; consequently, only the 25 per cent of the cases that would have appeared among the initial nonreactors could have been prevented if vaccination had been completely effective.

Tuberculosis case rates among nonreactors were low. In Puerto Rico the rate was 43 per 100,000 per year among controls and 30 among vaccinees. The difference, representing 31 per cent fewer cases among the vaccinees than among the controls is statistically significant. In the Muscogee-Russell trial, the corresponding rates were 22 among control and 14 among vaccinees, but the difference (36 per cent) is not statistically significant. If all nonreactors had been vaccinated, the total number of cases in the study populations would have been reduced by 8 to 9 per cent—an estimate obtained by applying a reduction of 31 to 36 per cent to the 25 per cent of the cases which would have appeared in those who could have been vaccinated.

The low case rates among nonreactors can be directly attributed to the present low risk of acquiring new infections. Evidence of low and falling infection rates in this country is found both in the present trials and in other recent studies. Because BCG cannot help those who are already infected, nor those who will not become infected, and may be helpful only to a portion of the decreasing few who will become infected in the future, it is apparent that vaccination cannot be very useful in controlling tuberculosis in this country. Moreover, with the rapid decline in tuberculous infection, the tuberculin test is becoming increasingly more valuable for epidemiologic, case-finding, and diagnostic purposes. These uses of the tuberculin test are destroyed by vaccination, which makes it virtually impossible to identify the naturally infected persons. And, as those who are already infected are now the group at greatest risk, it is upon them that tuberculosis control activities should be focussed if the disease is to be eradicated. The position is taken that in most situations in this country today the advantages of vaccination are outweighed by the disadvantages.

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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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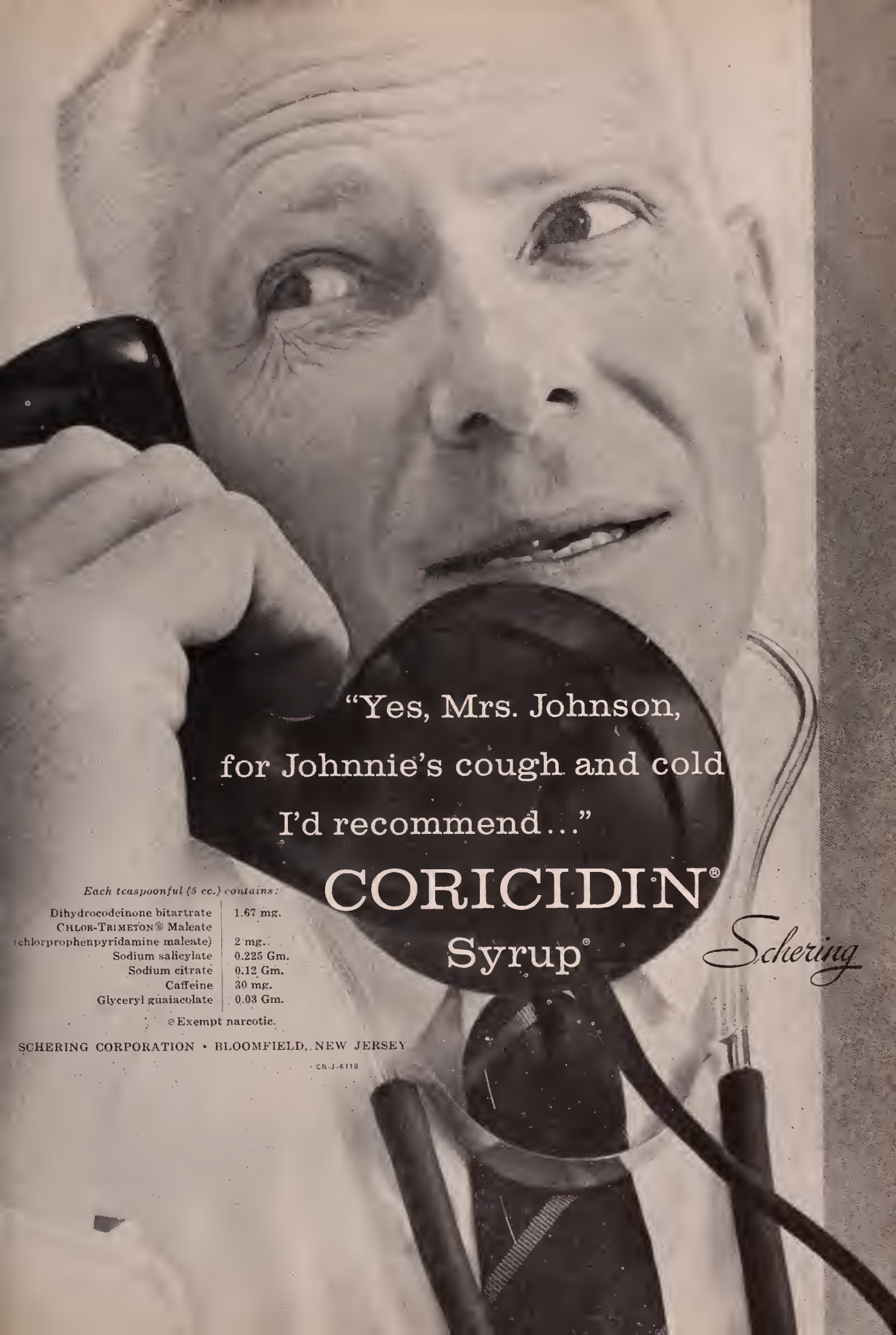
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Each teaspoonful (5 cc.) contains:

Dihydrocodeinone bitartrate	1.67 mg.
CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	2 mg.
Sodium salicylate	0.225 Gm.
Sodium citrate	0.12 Gm.
Caffeine	30 mg.
Glyceryl guaiacolate	0.03 Gm.

°Exempt narcotic.

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Capsules / Oral Suspension

designed for effective control of common gram-positive infections

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Division, Chas. Pfizer & Co., Inc. SCIENCE FOR THE WORLD'S WELL-BEING

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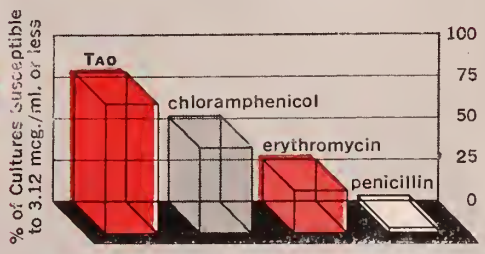
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

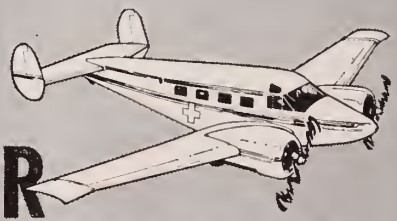
Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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PSYCHIATRY "The psychiatrist often finds it the agent of choice... much less likely to produce mental excitement" Current Concepts in Therapy: Sedative-Hypnotic Drugs II. Chloral Hydrate. New England J. Med. 255: 706 (Oct. 11) 1956.

Adults: 1 or 2 7½ gr. capsules or 1 or 2 teaspoonfuls of Noctec Solution 15 to 30 minutes before bedtime.

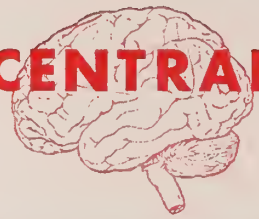
Children: 1 or 2 3¾ gr. capsules or ¼ to 1 teaspoonful of Noctec Solution 15 to 30 minutes before bedtime.

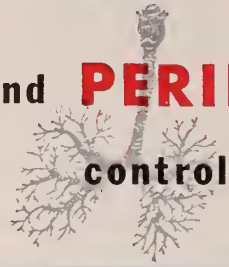
Supply: 7½ and 3¾ gr. capsules, bottles of 100. Solution, 7½ gr. per 5 cc. teaspoonful, bottles of 1 pint.

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Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
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For clinical supply and literature, write Dept. 15E

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8:504, *Dec. 1957.*

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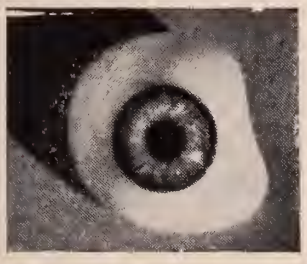
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1. Levy, S.: J.A.M.A. 153:1260, 1953.

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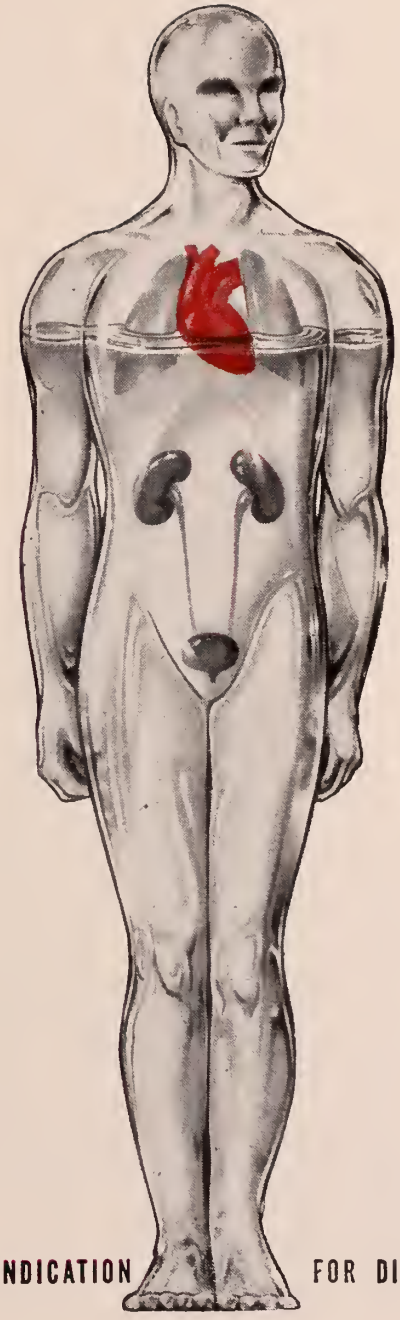
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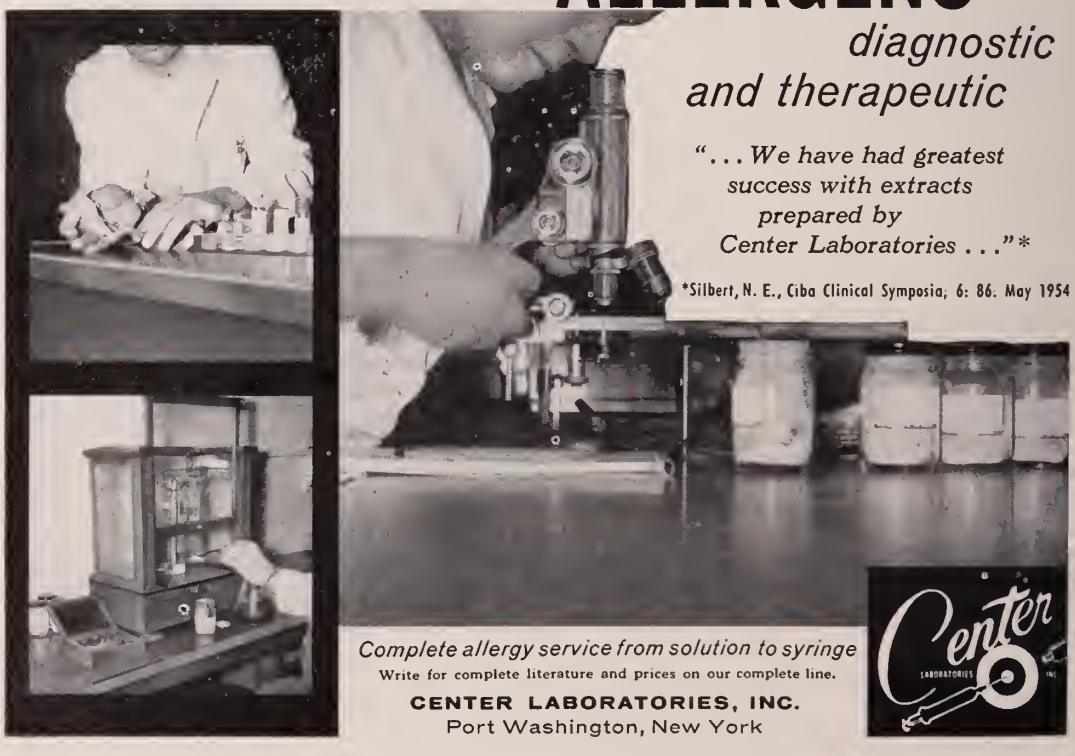
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*Silbert, N. E., Ciba Clinical Symposia, 6: 86. May 1954



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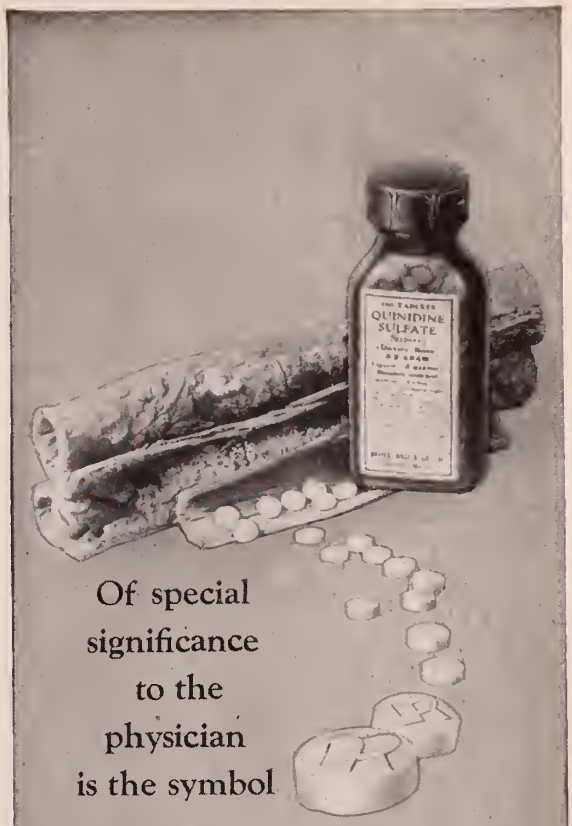
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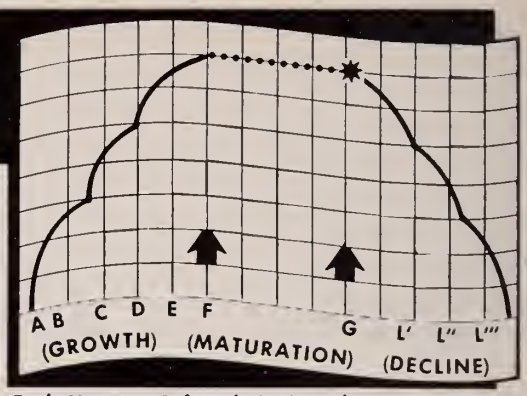
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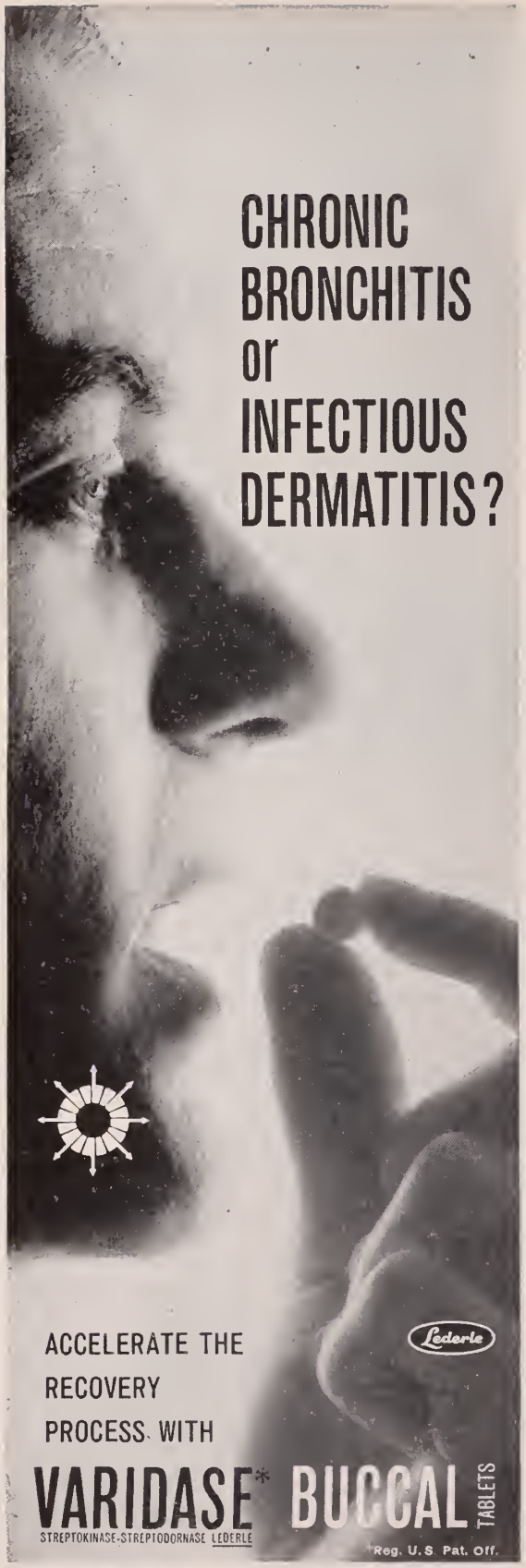
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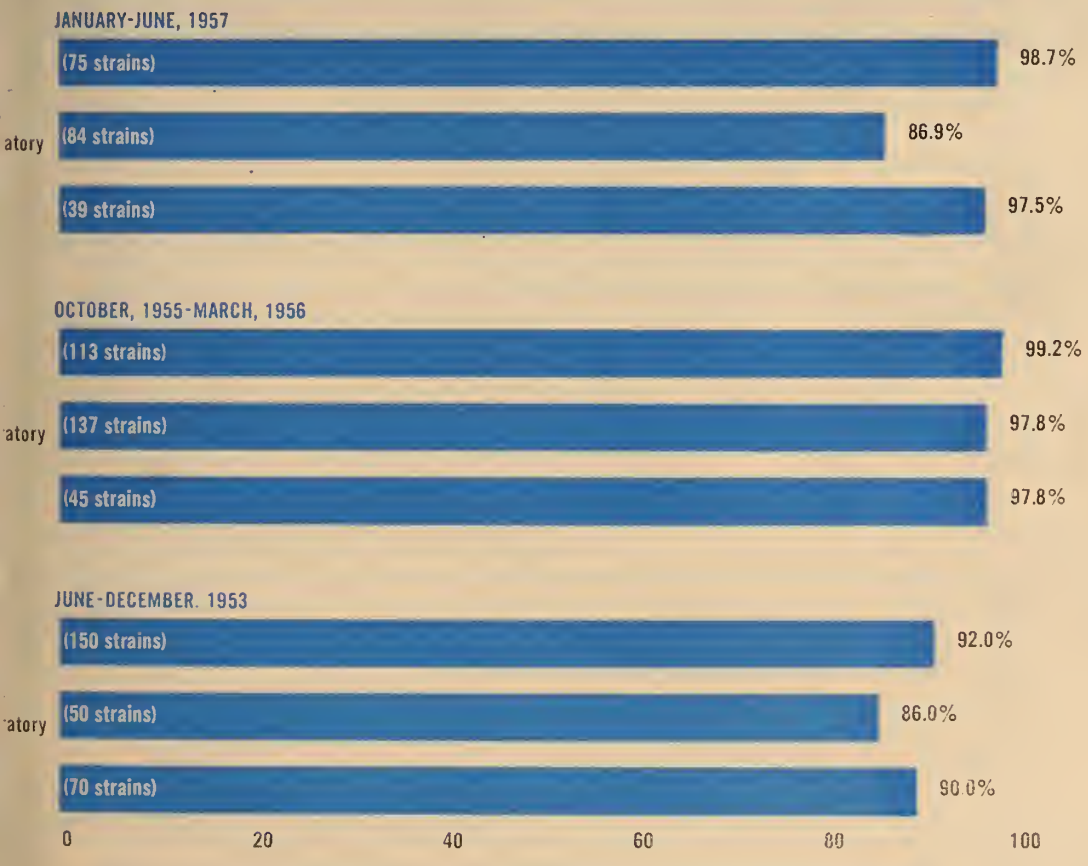
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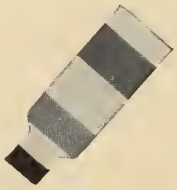
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destroys all **3** *principal pathogens*

Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

℞ NEW BOX OF 24 SUPPOSITORIES WITH APPLICATOR FOR MORE PRACTICAL AND ECONOMICAL THERAPY.

NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

EATON LABORATORIES, NORWICH, NEW YORK



In Biliary Distress

ZANCHOL®

Improves Flow and Color of Bile

Zanchol (brand of florantyrone), a distinct chemical entity unrelated to the bile salts, provides the medical profession with a new and potent hydrocholeretic for treating disorders of the biliary tract.

The high degree of therapeutic activity of this new compound and its negligible side reactions yield distinct clinical advantages.

- Zanchol produces a bile low in sediment.
- Zanchol enhances the abstergent quality of bile.
- Zanchol produces a deep, brilliant green bile, regardless of its original color, suggesting improved hepatic function.
- Zanchol improves the flow and quantity of bile without increasing total bile solids.

Bile with these qualities minimizes biliary stasis, reduces sediment and debris in the bile ducts and discourages the ascent of infection.

For these reasons ZANCHOL has shown itself to be a highly valuable agent in chronic cholecystitis, cholangitis and care of patients following cholecystectomy.

Administration: One tablet three or four times a day. Zanchol is supplied in tablets of 250 mg. each. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Mazola® Corn Oil...a palatable food effective in the management and control of serum cholesterol levels

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal... high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

CORN PRODUCTS
REFINING COMPANY



MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

ACHROCIDIN®

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



NOLUDAR "produced satisfactory results in terms of the time of onset and the duration of sleep. No side effects were encountered. The patients were well pleased with the quality of sleep."*

With NOLUDAR there is no preliminary excitation . . . no disturbing dreams . . . no residual grogginess. Non-barbiturate, non-habit forming, NOLUDAR brings your patients an improved quality of sleep.

*O. Brandman, J. Coniaris, and H. E. Keller: J. M. Soc. New Jersey 52:246 , 1955.

NOLUDAR®—brand of methyprylon

ROCHE LABORATORIES • DIVISION OF HOFFMANN-LA ROCHE INC. • NUTLEY, N. J.

ROCHE

f you were to examine these patients



could you detect the asthmatic on Medrol*?

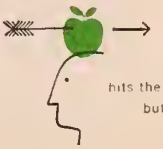
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol hits the **disease,** but spares the **patient**

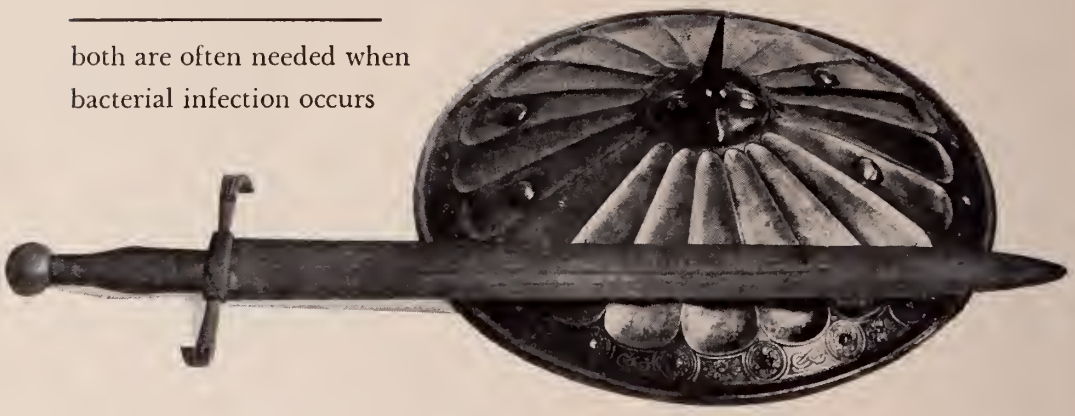
Upjohn

The Upjohn Company, Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN

▮ prompt, aggressive
antibiotic action
▮ a reliable defense against
monilial complications

both are often needed when
bacterial infection occurs



for a direct strike at infection
Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications
Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules *(250 mg./250,000 u.), bottles of 16 and 100.* Half-strength Capsules *(125 mg./125,000 u.), bottles of 16 and 100.*
Suspension *(125 mg./125,000 u. per 5 cc.) 60 cc. bottles.* Pediatric Drops *(100 mg./100,000 u. per cc.). 10 cc. dropper bottles.*

SQUIBB *Squibb Quality — the Priceless Ingredient*

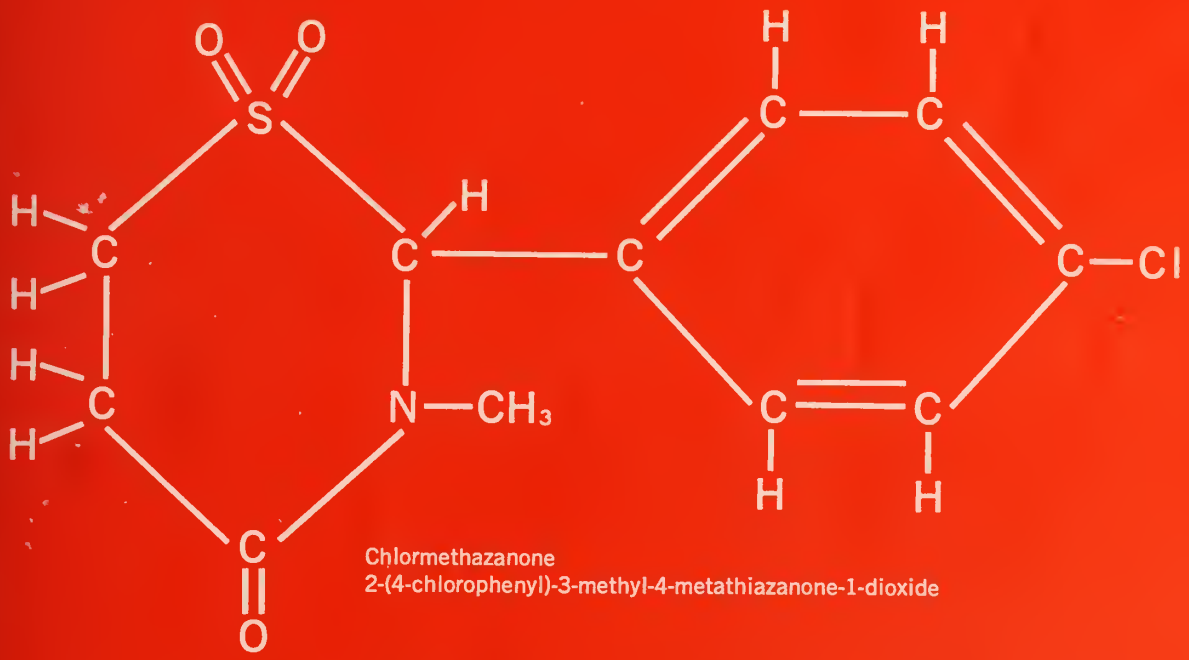
"MYSTECLIN"®, "SUMYCIN"®, AND "MYCOSTATIN"® ARE SQUIBB TRADEMARKS

Winthrop Laboratories
introduces

Tancopal

BRAND OF CHLORMETHAZANON

a completely new major chemical contribution to therapeuti



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

isolated chemically to in
other drug in current use

designed to be equally effective as both

a MUSCLE RELAXANT

a TRANQUILIZER

Trancopal

*the first true "TRANQUILAXANT"**

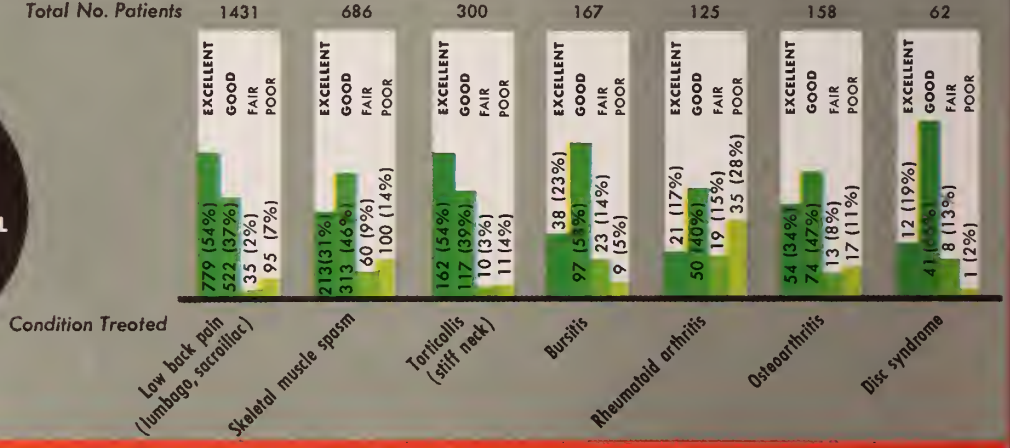
offering new freedom for your patients... from muscle spasm, from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'sa
[< L. tranquillus, quiet; L. laxare
loosen, as the muscles]

EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtma

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective wh
other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number
tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.

TRANCOPAL
IN MUSCULOSKELETAL DISORDERS



TRANCOPAL
IN PSYCHOGENIC DISORDERS



TRANCOPAL . . . the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.

CLINICAL RESULTS IN 4092 PATIENTS



MUSCULOSKELETAL CONDITIONS
2929 Patients

+



PSYCHOGENIC CONDITIONS
♂163 Patients

=

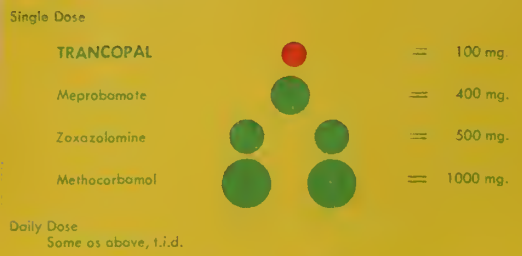


TOTAL 4092 Patients

MAJOR IMPROVEMENT
84%

Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY



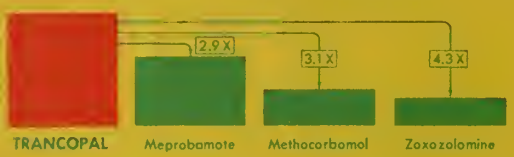
Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

Trancopal

the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

Winthrop Laboratories • New York 18, N. Y.

• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperal Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exp Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Ther 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Sur A. R.; Webb, W. G., and Gesler, R . M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

Printed in U. S. A. 11-58 (39

1 Ladeez and gentlemen:
learn all about new VITERRA PEDIATRIC,
a good supplement
in a great new package.



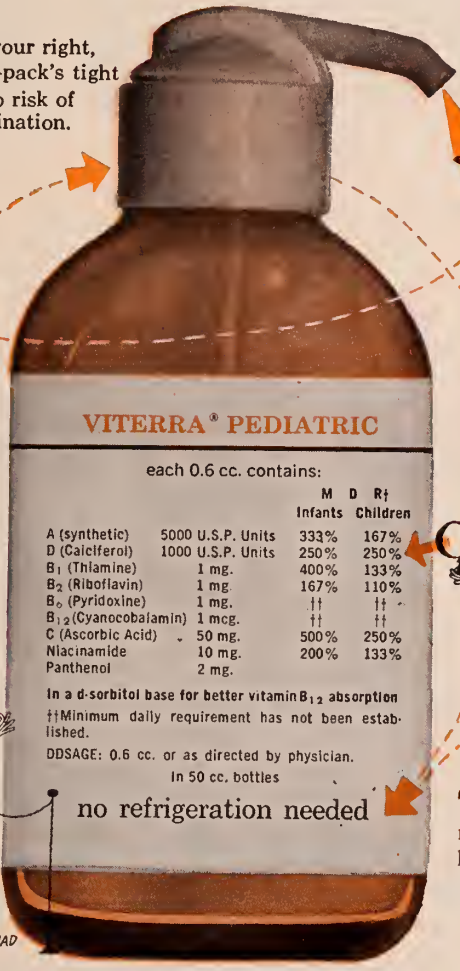
2 First,
see what happens when
you push the metered plunger.

3 Aha!
An exact 0.6 cc.
comes out this spout.
Never more, never less.



4 And notice –
no drip, no waste,
no sticky bottle.

5 On your right,
see Flo-pack's tight
seal. No risk of
contamination.



6 Let's take a minute
to admire the formula.





7 *That* means
no hot-weather
loss of potency.



8 Now for a farewell treat, a taste of delicious, orange-y VITERRA PEDIATRIC. How will you have it – in fruit juice? On cereal? Straight from the spoon?

VITERRA® PEDIATRIC



METERED FLO-PACK

Special note to doctors who took this tour:

Problems of over- and under-dosage, spillage, spoilage or leakage disappear with VITERRA PEDIATRIC'S new metered Flo-pack. Why not consider these advantages when you recommend a vitamin supplement?

ROERIG NEW YORK 17, N.Y. | Division, Chas. Pfizer & Co., Inc. | SCIENCE FOR THE WORLD'S WELL-BEING

to relieve edema of

DIURIL®

CHLOROTHIAZIDE

FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

DIURIL (Chlorothiazide) given alone to 85 patients, ". . . caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. . . . The average effective dose was found to be 1 Gm. per day by mouth. . . . The usually excellent response coupled with the absence of significant toxicity and lack of development of drug resistance makes chlorothiazide ideal for the prevention and treatment of toxemia."

DOSAGE: one or two 500 mg. tablets of DIURIL once or twice a day.

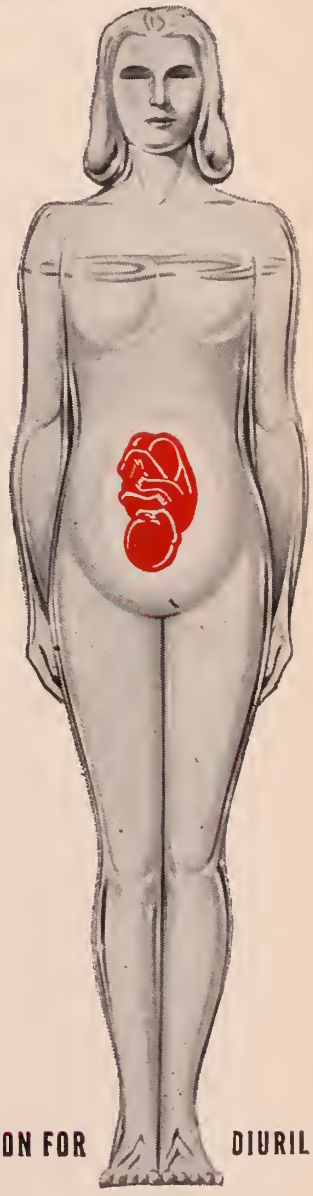
SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide); bottles of 100 and 1,000.

DIURIL is a trademark of Merck & Co., Inc.

©1958 Merck & Co., Inc.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

pregnancy



.....caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria....”

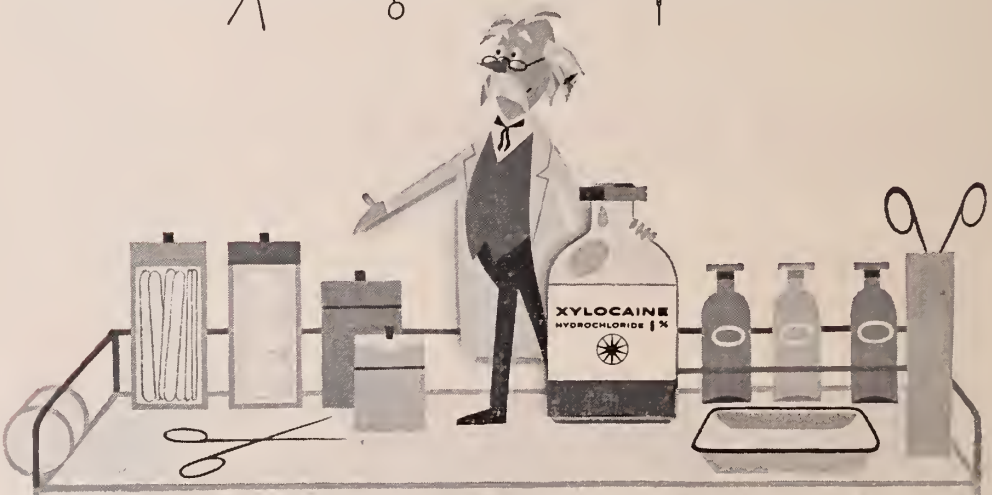
ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

IN OFFICE SURGERY

ELECTIVE AND TRAUMATIC

use XYLOCAINE *first...*
as a local anesthetic
or a topical anesthetic

SWAB SPRAY INFILTRATION NERVE BLOCK



Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

XYLOCAINE® HCl SOLUTION
(brand of lidocaine*)

Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.

See PDR

*U.S. PAT. NO. 2,441,498 MADE IN U.S.A.

for depression

▲Deprol▲†

Clinically confirmed in over 1,500 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation
► restores natural sleep
► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function
► causes no excessive elation
► produces no liver toxicity
► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia
► produces no amphetamine-like jitteriness
► does not depress appetite
► has no depression-producing aftereffects
► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE-MARK
CD-7469

Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N.J.*



Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

D 27

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

'TABLOID'

'EMPIRIN' COMPOUND®

WITH

CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations

Symbols OF PROVEN PAIN RELIEF



gr. 1



gr. ½



gr. ¼



gr. ⅛

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*



Codeine Phosphate . . . . . gr. ½
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

'CODEMPIRAL'® NO. 2*



Codeine Phosphate . . . . . gr. ¼
Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

..from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

'TABLOID'

'EMPIRIN' COMPOUND®



Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½
Caffeine . . . . . gr. ½

...from mild pain complicated by tension and restlessness.

'EMPIRAL'®



Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
Aspirin (Acetylsalicylic Acid) . . . . . gr. 3½

*Subject to Federal Narcotic Regulations

BURROUGHS WELLCOME & CO. (U.S.A.) INC. Tuckahoe, New York

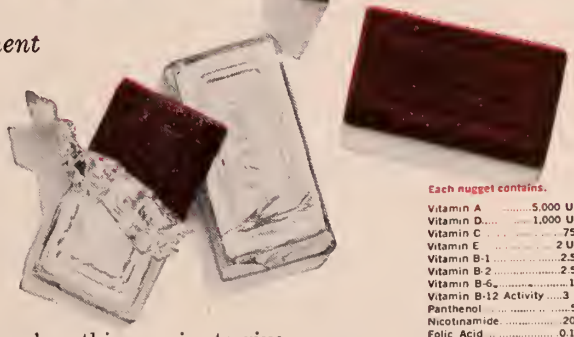
whenever
he
starts
to



he's
ready
for

Delectavites®

New vitamin-mineral supplement
in delicious chocolate-like nuggets



There's nothing easier to give
or take—
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

Each nugget contains:

Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.

WHITE LABORATORIES, INC.,
KENILWORTH, N. J.

now—an antibiotic troche that

STOPS COUGH TOO





The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

PRESCRIBE

Pentazets®

antitussive—antibiotic-anesthetic—analgesic troches

MSD MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

CM-8043

A NEW DIMENSION IN SOUND REALISM

WEBCOR

STEREOFONIC HIGH-FIDELITY

new listening luxury for your home!

STEREO by WEBCOR

Listen to new stereofonic music on a Webcor! You'll hear music with all its glorious tones and dimensions . . . all about you! This is listening enjoyment at its finest . . . *on a Webcor!*

See and hear the Victorian now . . . plus the complete new Webcor line for '59!



Victorian Stereo-Fidelity Radio-Fonograf plays stereo and monaural records. It features "Magic Mind" Stereo-Diskchanger, three speakers, and 15-watt amplifier, sensitive 13 tube AM-FM radio-fono combination. In hand-rubbed Mahogany. Only **$319.95.** Maple (slightly higher). Without radio **$229.95.**

Stereo Mate I—Matching external Amplifier-Speaker system for the Victorian Console. Mahogany, **$79.50.** Maple (slightly higher).

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STEREO MUSIC SOUNDS BETTER ON A WEBCOR

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in all diarrheas

CREMOMYCIN®

SUCCINYLSULFATHIAZOLE—NEOMYCIN SUSPENSION WITH PECTIN & KAOLIN

EXPERIENCE

MORE THAN 16 MILLION DOSES ADMINISTERED WITH SAFETY AND EFFICACY.

regardless of etiology

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Now—All cold symptoms can be controlled

This new timed-release tablet provides:

- *...the superior decongestant and antihistaminic action of Triaminic*
- *...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks*
- *...an expectorant to help the patient expel thickened mucus*
- *...the specific antipyretic and analgesic effect of well-tolerated APAP*
- *...the prompt and prolonged activity of timed-release medication*

Each* TUSSAGESIC *Tablet contains:

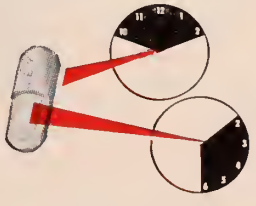
TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

Also available:
for those who prefer liquid medication—

Tussagesic suspension

In each 5 ml.: Triaminic, 25 mg.; Dormethan, 15 mg.; terpin hydrate, 90 mg.; APAP, 120 mg.

Tussagesic timed-release tablets provide relief in minutes, which lasts for hours



first—3 to 4 hours of relief from the outer layer

then—3 to 4 more hours of relief from the inner core

Dosage: 1 tablet in the morning, mid-afternoon, and evening, if needed. Should be swallowed whole to preserve the timed-release action.
Suspension: Adults—1-2 tsp. every 3-4 hours; Children 6-12 years old—1 tsp. every 3-4 hours; Children under 6—dosage in proportion.

NEW Tussagesic*

*Contains TRIAMINIC to STOP running noses and open stuffed noses orally

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CLINICAL BRIEFS FOR MODERN PRACTICE



if your patient wears tinted glasses and sighs frequently...?

She may have an anxiety state. The tinted glasses may be worn as a shield against the world—and to relieve the photophobia resulting from pupillary dilatation caused by anxiety-induced hyperadrenalism. The sighs may be a result of fatigue from emotional unrest.

Source—Meyer, O. O.: Northwest Med. *53*:1006, 1954.

*4 findings from a recent study**

calmative **nostyn**® Ectylurea, AMES (2-ethyl-*cis*-crotonylurea)

1. Anxiety and nervous tension appeared to be most benefited by NOSTYN.
2. Seventy per cent of patients obtained some degree of relief.
3. Greater inward security and serenity were experienced and expressed.
4. Mental depression did not develop in patients previously depressed by meprobamate or a similar drug.

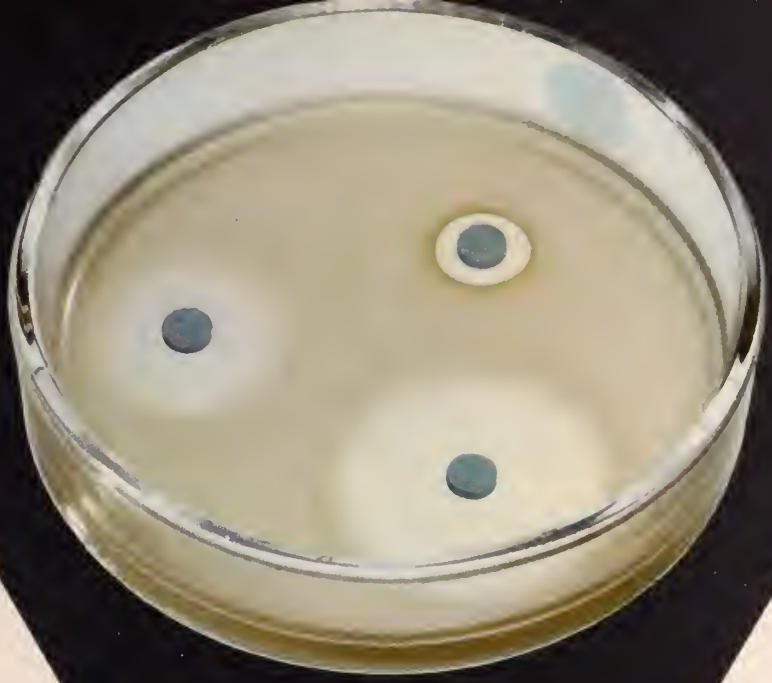
dosage: 150-300 mg. (½ or 1 tablet) three or four times daily. *supplied:* NOSTYN tablets, 300 mg., scored. Bottles of 48 and 500.

*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: New York J. Med. *58*:520 (Feb. 15) 1958.

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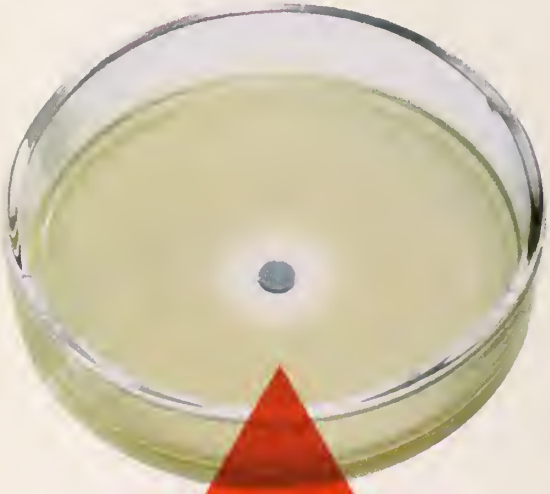
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infections

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Erythrocin®

stearate

(Erythromycin Stearate, Abbott)



against staph-, strep- and pneumococci

indications:

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

dosage:

Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

supplied:

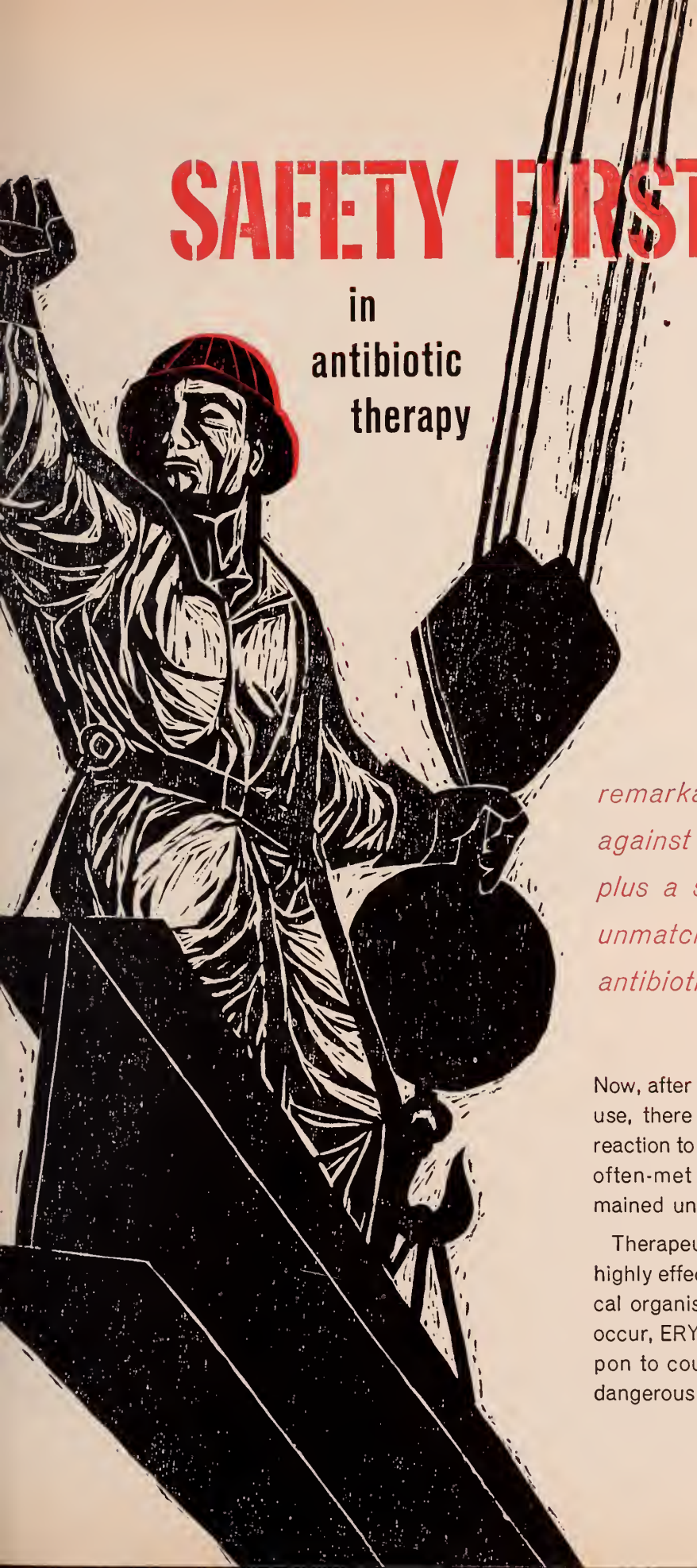
In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab—Film-sealed tablets, Abbott; pat. applied for.

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SAFETY FIRST

in antibiotic therapy



remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

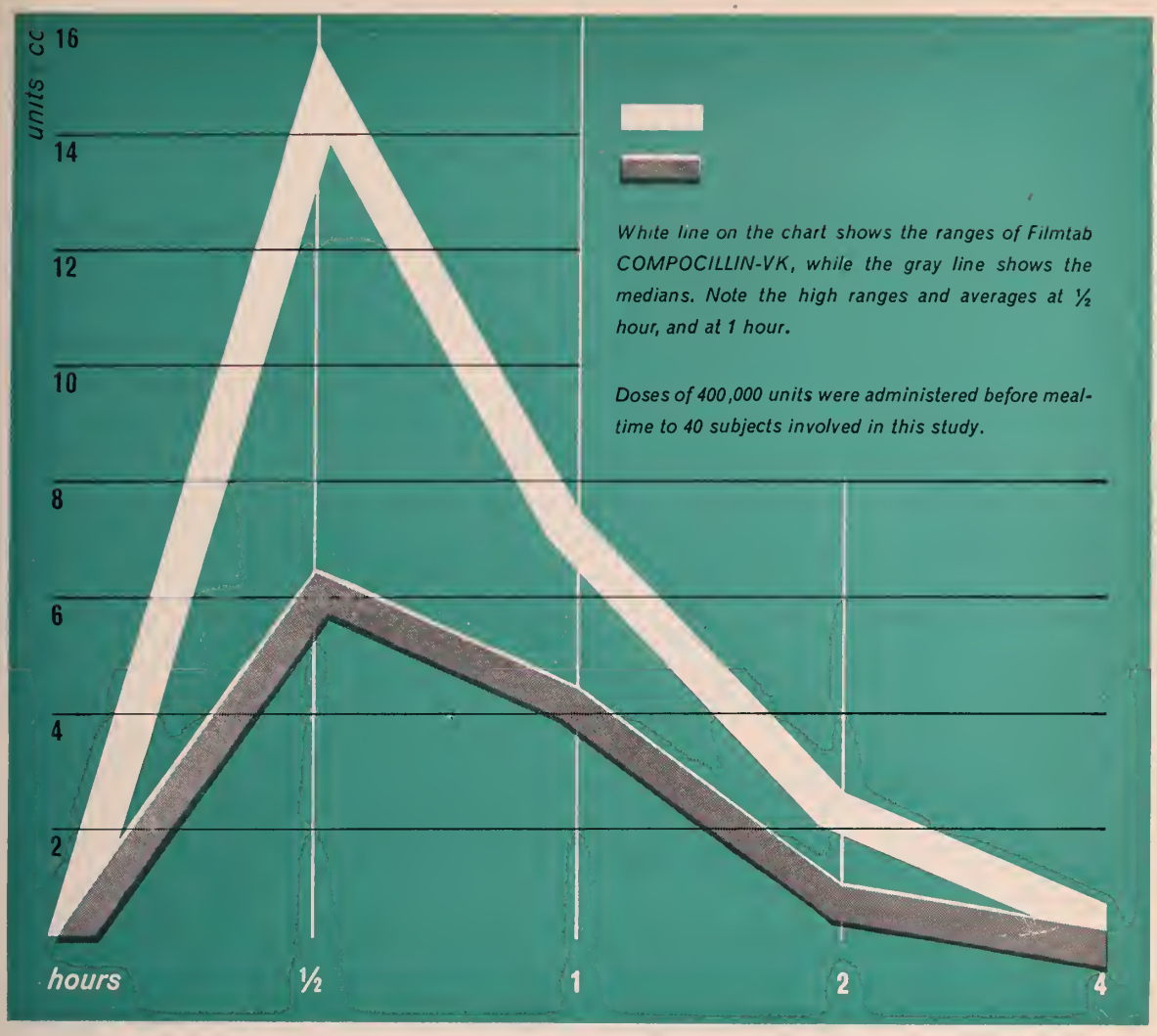
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the higher blood levels of COMPOCILLIN-VK®

Potassium
Penicillin V

809156



Now, in both Filmtab and Oral Solution, patients get high penicillin V blood levels with Compocillin-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

Compocillin-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

Compocillin-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott



the most effective antibiotic available against staphylococci

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(RISTOCETIN, ABBOTT)

PREPARED FROM PURE CRYSTALS

Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

Provides Bactericidal Action Against Coccal Infections[1]

Provides Successful Short-Term Therapy In Endocarditis[2]

812189

Now, after just 12 months, SPONTIN has become an outstanding drug of choice against resistant staphylococci, and in other serious coccal infections.

Six papers presented at the Antibiotics Symposium[1] reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical reponses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report[3] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

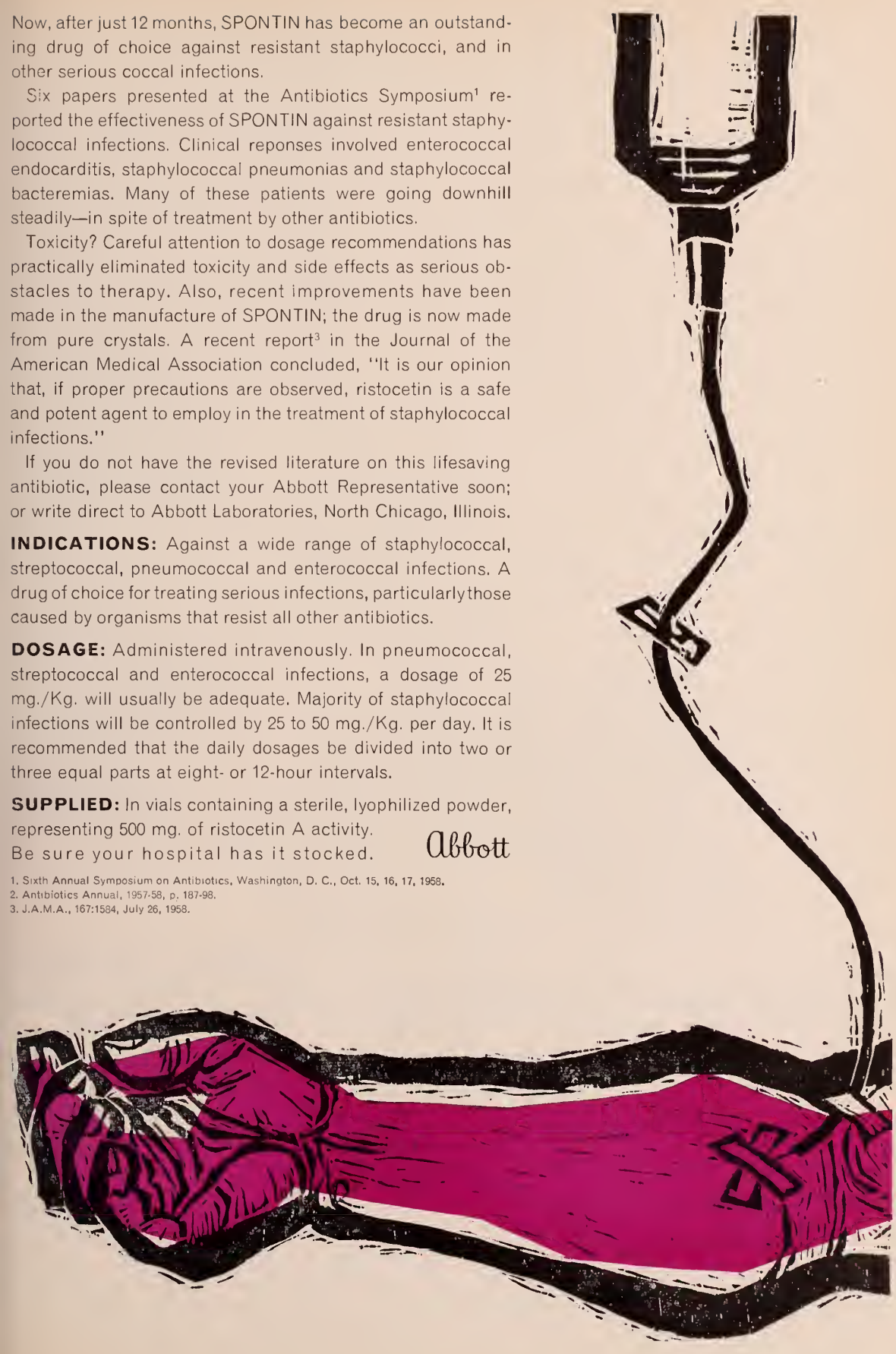
INDICATIONS: Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularly those caused by organisms that resist all other antibiotics.

DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.
Be sure your hospital has it stocked.

Abbott

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
2. Antibiotics Annual, 1957-58, p. 187-98.
3. J.A.M.A., 167:1584, July 26, 1958.



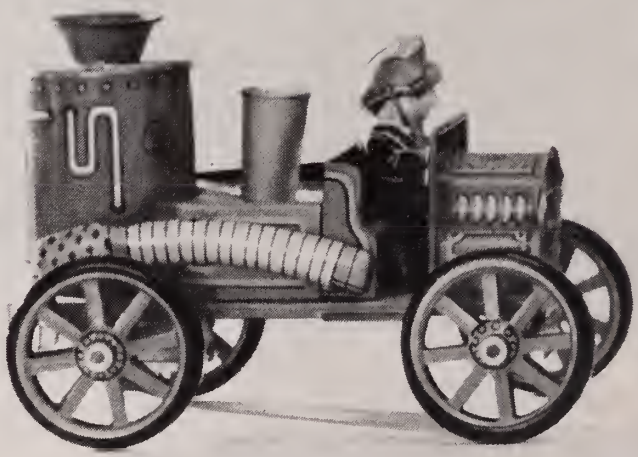
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new, exclusive



Prednis-CVP®

dual anti-inflammatory

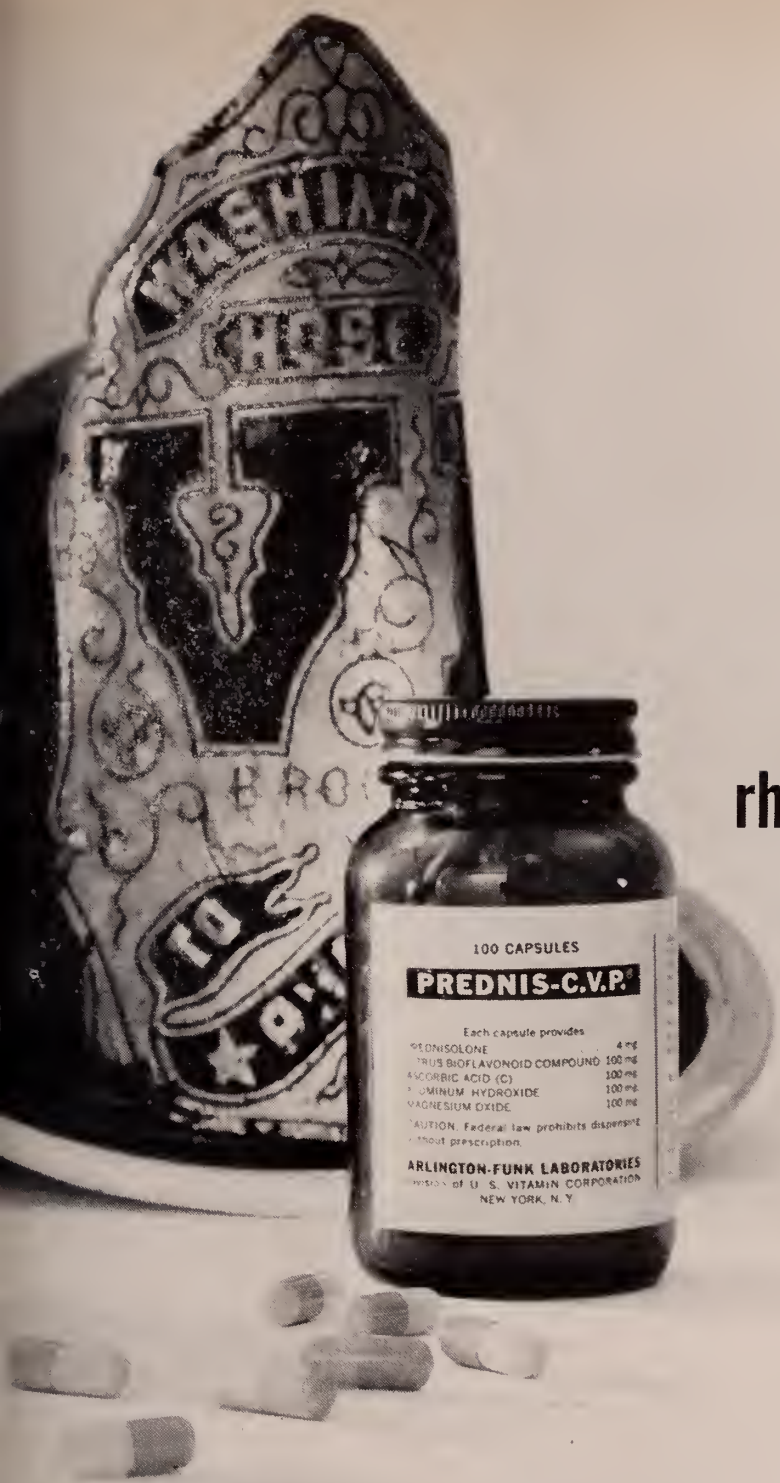
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potent, prompt, sustained action with prednisolone

inflammatory-corrective . . .
reduction of abnormal capillary permeability with citrus bioflavonoids

"built-in" protection

with citrus bioflavonoids . . .
against ecchymoses, purpuras, gastric hemorrhage and other steroid-induced capillary damage

with antacids . . .
against gastric distress, digestive upsets, nausea



in rheumatoid arthritis bronchial asthma eczemas

and other inflammatory, allergic and rheumatic conditions

suggested dosage:

Average initial dose, 2 to 5 capsules daily, in divided doses; in severe cases, 6 to 10 capsules daily. Gradually reduce dosage to effective maintenance level.

Bottles of 30, 100 and 500 capsules.

Each **PREDNIS-C.V.P.** capsule provides:	
PREDNISOLONE	4 m
CITRUS BIOFLAVONOID COMPOUND	100 m
ASCORBIC ACID (C)	100 m
ALUMINUM HYDROXIDE	100 m
MAGNESIUM OXIDE	100 m

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For Real Pain ...give real relief:

A.P.C. WITH Demerol®
tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

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Walker-Gordon Certified Milk With Sodium Content Decreased 90%
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For use in low-salt diets. **Very Important:** THIS IS A FRESH, FLUID MILK WHICH TASTES JUST AS GOOD AS THE CERTIFIED MILK FROM WHICH IT IS MADE. Paper half-pints for hospitals, quart bottles for home delivery.

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a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy



Decadron*

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

a new order of magnitude

In Anti-Inflammatory Potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

In Dosage Reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

In Elimination and Reduction of Side Effects

Virtual absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions has been noted with DECADRON.[1,2,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and digestive complaints were rare. Nor have there been any new or "peculiar" side effects, such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia or erythema. Thus DECADRON introduces a new order of magnitude in safety, unprecedented in corticosteroid therapy.

In Therapeutic Effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency.[4] Clinically, this was manifested by a higher degree of improvement in many patients, previously treated with prednisteroids,[3] and by achievement of satisfactory control in an impressive number of recalcitrant cases.[3,4]

In Therapeutic Range

More patients can be treated more effectively with DECADRON. Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nearly all patients on DECADRON, assures greater patient cooperation.

References:

1. Boland, E.W.: California Med. 88:417 (June) 1958.
2. Bunim, J.J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958.
3. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.
4. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

DOSAGE AND ADMINISTRATION

With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

One 0.75 mg. tablet of DECADRON (dexamethasone) replaces:

One 4 mg.	One 5 mg.	One 20 mg.	One 25 mg.
tablet of methylprednisolone or triamcinolone	tablet of prednisolone or prednisone	tablet of hydrocortisone	tablet of cortisone

SUPPLIED:

As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets to provide maximal individualized flexibility of dosage adjustment.

Detailed literature is available to physicians on request.

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Decadron*

DEXAMETHASONE

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a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy



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to treat more patients more effectively

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INTRAMUSCULAR IRON-DEXTRAN COMPLEX

CHRONIC BLOOD LOSS:

"...this patient did not receive any transfusion of blood or any hematinic other than the intramuscular dose of iron. His initial concentration of hemoglobin measured 5.8 gm. per 100 cc. of blood and in spite of operation [hemorrhoidectomy] and further loss of blood the concentration increased to 12.2 gm. within less than 3 weeks. Concomitantly with the hematologic improvement there was clinical improvement and subsidence of the initial primary symptoms [unusual fatigability, dyspnea, palpitation on exertion]."[1]

INTOLERANCE TO ORAL IRON:

"...she had an excellent response with a reticulocyte peak of 5.3 per cent on the seventh day, and a complete disappearance of the anemia and conversion from hypochromic to normochromic cells by the end of two months. She experienced remarkable improvement in pep and sense of well-being coincident with the alleviation of her anemia."[2]

(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

Supplied: 2-cc. and 5-cc. ampuls, boxes of 4. Physician's directions in every box. There are 50 mg. of elemental iron per cc. Request brochure NDA 17, Imferon.

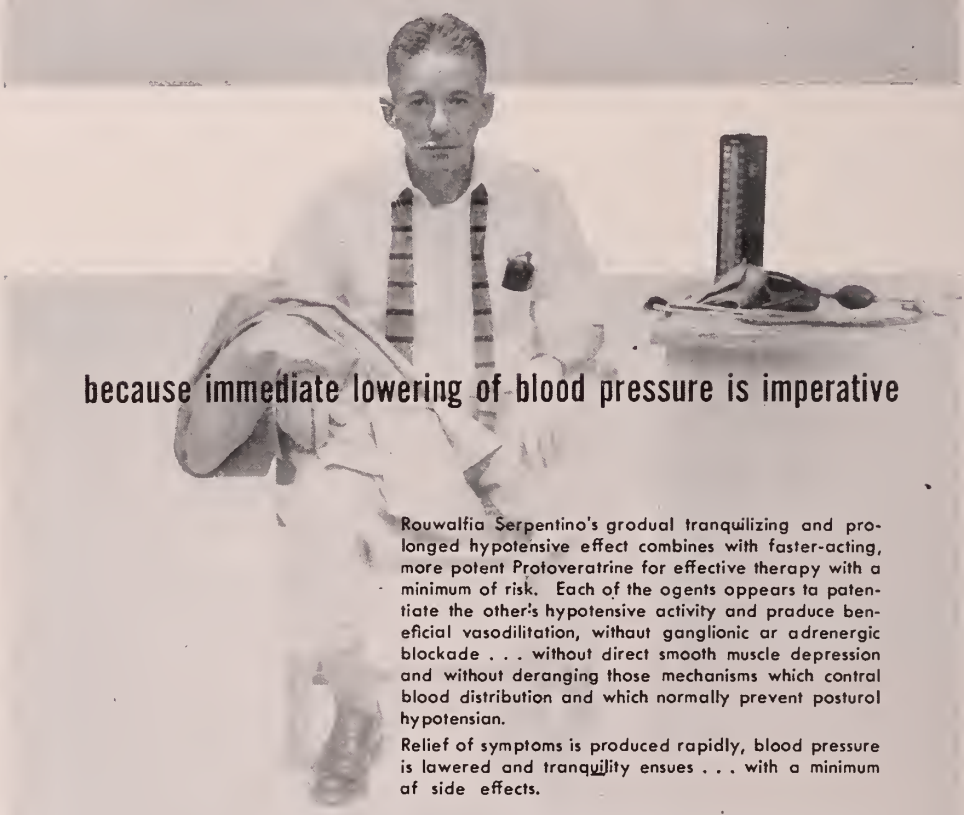
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diagnosis: **hypertension, moderate to severe**

prescribed: **Rauprote***

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because immediate lowering of blood pressure is imperative

Rouwalfia Serpentino's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protoveratrine for effective therapy with a minimum of risk. Each of the ogents oppears to patentiate the other's hypotensive activity and praduce beneficial vasodilitation, withaut ganglionic ar adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which contral blood distribution and which normally prevent posturol hypotensian.

Relief of symptoms is produced rapidly, blood pressure is lawered and tranquility ensues . . . with a minimum af side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial *New England J. Med.* 258:48-49, 1958.

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"Much better– thank you, doctor"

Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
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And now in practice

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COSA-TETRACYN*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.
(for pediatric or long-term therapy)

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.)
2 oz. bottle

NEW! PEDIATRIC DROPS
(orange-flavored) 5 mg. per drop, calibrated dropper, 10 cc. bottle

COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York*

Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

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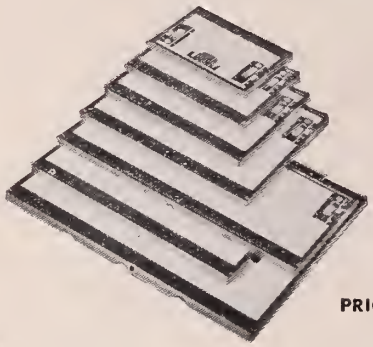
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1. Levy, S.: J.A.M.A. 153:1260, 1953.

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Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production ... nutrition participates in the prophylaxis against most acute infections ..."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions ... Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

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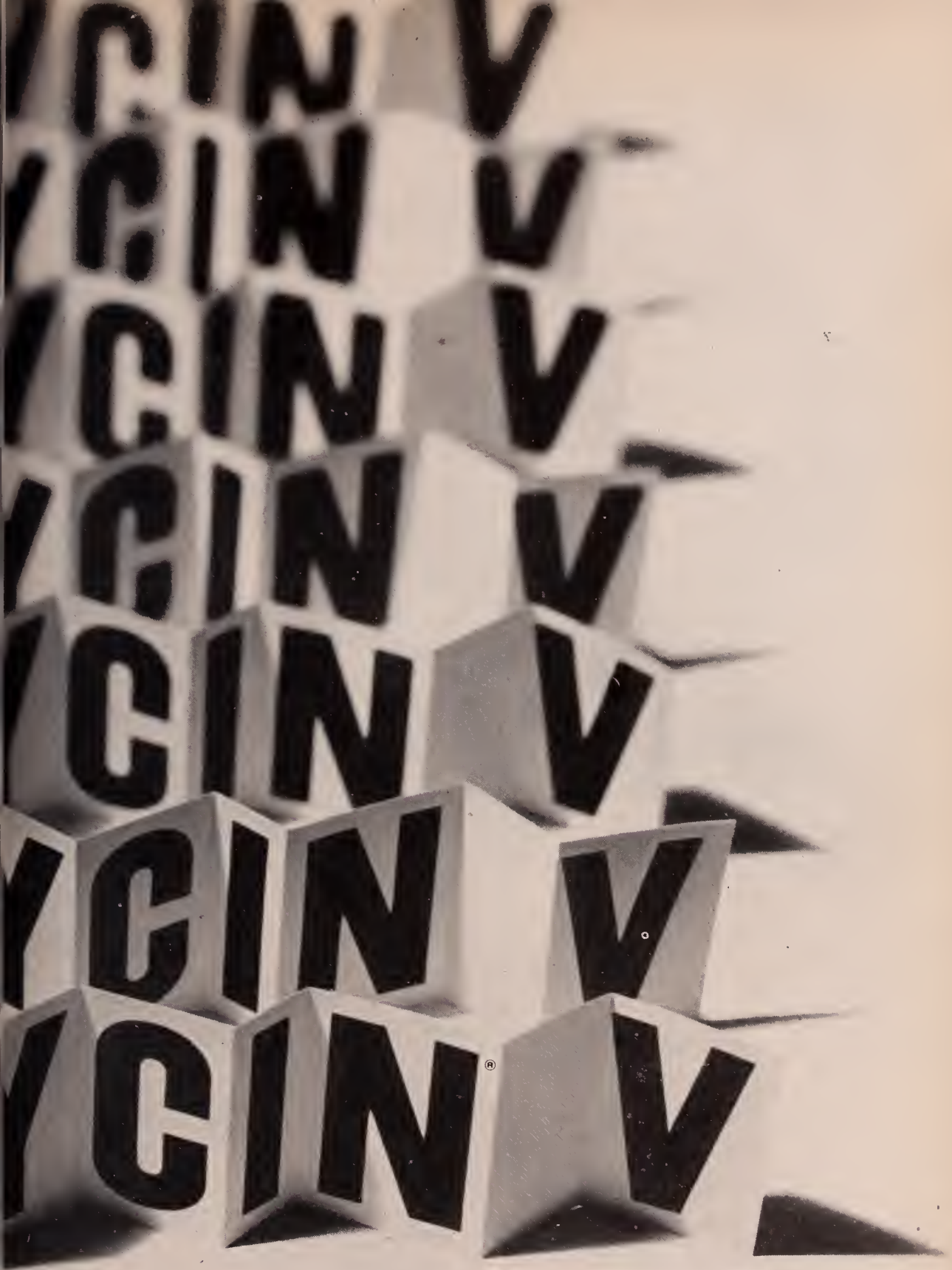
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References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

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THE JOURNAL
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Editorials • • •

The Last Horseman

For centuries, infection was the great killer. A cut finger might lead to "blood poisoning" and all the art of the doctor, and the terrible vigil of the family were useless. The animalcules multiplied and killed the host. And now we have reason to hope that the fear of infection may, by the end of our children's generation, be substantially banished.

Infection slaughtered men and women and children. It had many names. It was the black death, the great plague. It was typhus and cholera. It was childbed fever and it haunted the halls of ancient hospitals striking down postoperative victims. It was the great pandemic, the scourge, the last horseman of the apocalypse. Indeed the number one cause of death was, for centuries, not heart disease, not cancer, not war, but malaria.

Infection stole away our children. Measles killed and so did scarlatina. Children were maimed by small-pox, ruptured their alveoli with whooping cough, and choked to death on diphtheritic membranes. Tuberculosis was the white plague and bubonic fever the black plague.

And then we began to attack these big little germs. The "we" does not mean just us doctors. It included doctors of course—practitioners at the bedside, research physicians in the laboratory, public health doctors in the field. Engineers drained swamps, entomologists trapped mosquitoes in the jungle, government officials threw the full weight of their approval behind health campaigns. The medical schools joined. The pharmaceutical industry did primary research and wrought miracles of production. Magazines and newspapers spread public education in the health field. Slum clearance workers eradicated many sources of infection. Health officers at every level joined in the crusade.

And it paid off. The infectious tide has receded. Children now are more threatened by automobiles than by bacteria. Millions saved from early death due to infection, have been preserved to die from cardiovascular disease

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or malignancy. Since all men are mortal, our accomplishments do not conquer death, they merely delay it.

Our triumph over infection is not complete. With the new assurance goes a new carelessness. Operating room discipline becomes lax as we become contumacious towards infection. And then the rate goes up. Tuberculosis hospitals get smaller, and more tuberculous patients are free in the community. Asepsis seems less important, so we grow careless. But the bright hope remains. We know that never again will a death warrant be written with the words, "infection has set in." If we do not throw away our triumph, we shall finally destroy this last horseman.

No More Hysteria

Under the current *Standard Nomenclature of Diseases and Operations*, you will look in vain for the diagnosis, "Hysteria." It does not appear at all, not even by cross reference, in the Disease Index of that bible of terminology. Since our hospitals are bound by the *Standard Nomenclature*, this means that "Hysteria" has been repealed. There is no more hysteria. It is now, perhaps, "conversion reaction" or "dissociation reaction" or maybe "emotionally unstable personality" if that is what you mean. The disappearance of the noun "hysteria" also carries into the limbo that useful adjective "hysterical" and that handy word "hysterics" —all of which are officially abolished. But not discarded from our everyday vocabulary. For a long time to come, doctors will continue to refer to "hysterical" symptoms, and laymen will speak of "hysterics."

It is a curious word, "hysteria." It has been in English ever since the language existed; and before that it was in the classical languages. The original idea was that sex had something to do with psychoneuroses. To the ancients it appeared that a frustrated uterus was the cause of the trouble. Well, the Greeks had a word for it: *hystera*, uterus. They believed that the organ became detached from its moorings and wandered around the body. In its wanderings it compressed the gut, pressured the carotids, irritated the heart, and benumbed the peripheral nerves, causing the variegated symptomatic pattern of hysteria. Even Hippocrates must have concurred. He recommended marriage as the remedy for hysteria. Galen was too sophisticated to accept the simple "wandering uterus" theory. He argued that the symptoms were due to engorgement of the uterus. For a millenium, the belief persisted that hysteria was an organic disease. Only in the enlightened 17th century was this idea abandoned. Then the devil's claw and other hysterical stigmata were considered to be evidence of bewitchment; and hysterical women could be conscientiously put to death as witches.

Even after the uterine origin of hysteria was discarded, it was hard to believe that men could have hysteria. The word itself inevitably suggested *uterus* to any one who knew Greek —and that applied for centuries to all doctors. Thus Sydenham knew that men could be neurotic—but he could not bring himself to say that men could have hysteria. He suggested that the corresponding condition in men be called hypochondriasis. Sydenham, incidentally, had a modern-sounding psychosomatic concept of the neurosis. He said that emotions became disturbed and affected the physically weakest part of the body producing neurotic symptoms.

In the 18th and 19th century, hysteria was associated with convulsions—grand hysteria, hysterical crises, even "hystero-epilepsy." Pinel thought of it as an involvement of the vegetative nervous system. Charcot taught that emotions affected the ovary which, through organic channels, produced hysteria—particularly the convulsions. Charcot then argued that if you influenced the emotions, through suggestion, you might cure the hysteria even though the organic change in the ovary would remain. It

was while studying at Charcot's clinic, that Freud developed his idea that hysteria was due to emotional conflicts stemming from childhood experiences. In 1895 Breuer and Freud published their famous *Studies in Hysteria* which launched modern psychodynamics. Here for the first time, was the thesis that hysteria was the result of a repressed idea, the energy of which was "converted" (hence *conversion*) into physical symptoms. Here, too, was developed the idea of an emotional purging of the unconscious thought—the concept of emotional "catharsis." Both Charcot and Freud knew that men could be as "hysterical" as women, and had no objection to using the word for both sexes. Freud's Viennese contemporaries, however, burst into laughter at the idea of a male having a uterine disorder. Even today, there are those who think that hysteria in man is different from hysteria in woman.*

Well, the question is now academic—at least in theory. Since the word "hysteria" has been abolished, there need be no more argument about it. The word is gone. But not, alas, the psychoneurosis.

Promise Her Anything, But—

The very first of the cranial nerves, the one at the head of the head, at the forefront of the brain, is the olfactory nerve. Smell is the basic sensation. Before there were men and women on the earth, there were animals whose odors and sense of odor kept the species going. Today, there are odors which might cause you to hold your nose, odors which once were experienced as potent aphrodisiacs.

And how precious is the frankincense! The very word means "pure odor" (free, that is free-of-contaminants, plus incense). To the botanist, frankincense is nothing but the volatile oil of the gum of the Boswellia tree. But to the poet and to the lover it is magic. So precious was frankincense that it was one of the gifts of the Magi. Frankincense is still the principal ingredient of the joss stick prayerfully burned before the household divinity of the pious Buddhist.

Once the pharmacist played on an odoriferous keyboard of wonderful scents. He knew how to blend eucalyptol and Cajuput Oil, sandalwood and myrrh and all the balsams of the world. Odor control was a part of pharmacognosy. Perfumes have played a role in history. They have made women desirable enough to warrant the sacrifice of a crown or an empire. They have concealed evil odors, as Lady Macbeth tried to do, but "all the perfumes of Araby will not sweeten this little hand."

The most complex part of the brain is the rhinencephalon, that respository and pathway for the most basic of senses. Nothing can provoke memories like a half-forgotten odor suddenly wafted to the nostrils. And smell can arouse more than memories. It can provoke fear and nausea, hate and love. It can inflame the appetite or destroy it, make a person attractive or so repellent that even his best friends won't tell him. A vast industry has been built on the stimulating of odors and an equally vast business in the manufacture of deodorants. But the pharmacist and the physician are no longer the curators of this ancient art. It has passed into more commercial hands. The promise and excitement of sweet smells has now become a problem in merchandising. The magic, however, remains. Promise her anything, but give her perfume. A commercial plug now, rather than a lovely poem. But more truth than poetry.

*For example, Robin, E. in the May 1, 1952, *New England Journal of Medicine,* found that males with hysteria had more obvious, less subtle gains from their disability than women; and that women had more spectacular symptoms than men.

WILLIAM J. DOUGHERTY, M.D., M.P.H.
Trenton

Today's Problems in Tuberculosis Control*

The new drugs have taken the edge off our fear of tuberculosis and may have taken much of the steam out of the anti-tuberculosis crusades of the first half of the century. This can lead but to a fool's paradise. Tuberculosis is still with us.

TUBERCULOSIS is a communicable disease of particular importance to the public health because it is a long-term illness. It affects family groups, causes economic distress, and is an important cause of death.

An evaluation of efforts in tuberculosis control includes consideration of the present status of infection in the state, methods employed in case finding and supervision, and a definition of future objectives.

TUBERCULOSIS IN NEW JERSEY

IN 1900 tuberculosis claimed 186 lives among each 100,000 persons in this state. Table 1 indicates death rates in successive years since 1950. In this period death rates due to tuberculosis have been drastically reduced. In the first decades of this century, one-third of deaths due to tuberculosis occurred in persons under 30 years of age. In 1956, deaths among persons up to 25 years of age were but three per cent of the state total. This remarkable progress has resulted from successive forward steps in patient care ranging from the establishment of sanatoria to the present era of antibiotic and chemotherapeutic agents.

TABLE 1.

TUBERCULOSIS DEATH RATES
Per 100,000 New Jersey 1950-1957

Year	Est. Pop.*	Deaths	Rate
1950	4,848,000	1,170	24.2
1951	4,896,000	1,022	20.9
1952	4,949,000	831	16.8
1953	5,006,000	693	13.8
1954	5,071,000	588	11.0
1955	5,151,000	570	11.1
1956	5,206,000	522	10.0
1957	5,279,000	521	9.9
			Provisional

*Mid-year estimates obtained by using the excess of births over deaths of 1950 Census to date of estimate. Excess was added to 1950 Census count and results rounded to nearest thousand.

However, in 1955 comparative information provided by the Public Health Service on cities of over 100,000 population revealed that among the 20 cities in the United States having the highest death rates, there were five New Jersey communities—Trenton, Camden, Jersey City, Elizabeth and Newark. The death rates per 100,000 for these cities during 1955-1957 are presented in Table 2. The decline observed must be accepted with caution for with relatively small numbers of deaths, rates may vary greatly from year to year. One of our major problems is reflected in these figures, for 35 to 40 per cent of deaths due to tuberculosis in this state are occurring in our principal cities.

*From the New Jersey State Department of Health, where Dr. Dougherty is a District State Health Officer. This paper was read, by invitation, before the Radiology Section at the May 20, 1958 Annual Meeting of The Medical Society of New Jersey.

TABLE 2.

TUBERCULOSIS DEATH RATES

Per 100,000 Selected Cities New Jersey 1955-1957

Area	1955 Deaths	1955 Rate	1956 Deaths	1956 Rate	1957 Deaths	1957 Rate
State	570	11.1	522	10.0	521	9.9
Camden	31	23.7	25	18.9	22	16.4
Elizabeth	21	17.6	17	14.2	15	12.4
Jersey City	57	18.2	39	12.3	39	12.2
Newark	82	17.7	88	18.8	84	17.8
Trenton	37	27.8	34	25.4	30	22.2
Selected Cities	228	20.0	204	17.4	190	16.1

Although there has been a marked decline in deaths due to tuberculosis, the decline in the rate at which new cases appear is not parallel. In 1957 the case rate of newly reported tuberculosis of all types was 67 per 100,000. Table 3 presents case rates for newly reported active tuberculosis since 1952. We may expect to find one new active case of tuberculosis for each 2,500 to 3,000 persons in the state each year. Another problem in tuberculosis control appears: the decline of active disease is relatively slow in our population.

TABLE 3.

ACTIVE TUBERCULOSIS CASE RATES

Per 100,000 New Jersey 1952-1957

Year	Est. Pop.*	Cases	Rate
1952	4,949,000	2,234	45.1
1953	5,006,000	2,285	45.6
1954	5,071,000	2,104	41.1
1955	5,141,000	2,139	41.7
1956	5,206,000	1,888	36.3
1957	5,279,000	1,806	34.2

*Mid-year estimates obtained by using the excess of births over deaths of 1950 Census to date of estimate. Excess was added to 1950 Census count and results rounded to nearest thousand.

The incidence of tuberculosis in New Jersey increases with advancing age, for 46 per cent of all newly reported cases are over 45 years of age. In 1957 newly reported active tuberculosis occurred in children up to age 15 at a rate of 9.4 per 100,000 (Table 4). The incidence of new active cases increases nearly three times in the age group 15 to 24 years. By age 45, rates are four times as high as in childhood. They progress to a level six times as high by age 65.

TABLE 4.

ACTIVE TUBERCULOSIS CASE RATES BY AGE GROUPS

Per 100,000 New Jersey 1957

Age Group	Cases	Rate
0-14	115	9.4
15-24	187	26.6
25-44	671	39.1
45-64	587	48.8
65 and over	241	55.8

Tuberculosis is more common among males and its incidence among non-whites is approximately four times that of the white population. Conservative estimates indicate that 85 per cent of newly reported active cases of tuberculosis have moderate to far advanced lesions.

Several problems are apparent: there is a moderate increase in incidence in the years between 15 and 24 and the frequency of moderate and far advanced lesions emphasizes the need for more intensive early detection efforts.

CASE FINDING

A BROAD program for discovering tuberculosis cases and assuring that they are under medical supervision is the cornerstone of effective tuberculosis control.

In such a program concerned with the discovery, treatment and eradication of tuberculosis, *every physician's office is a detection center*. The daily census of physicians' patients numbers thousands and indicates the potential of a physician centered screening effort. A high index of suspicion and judicious use of screening and diagnostic procedures yield outstanding results in tuberculosis detection.

Each year many thousands of persons are admitted to the hospitals of the state. The

principle of an admission chest x-ray examination as a tuberculosis case finding method has received widespread acceptance. In 1957, hospitals cooperating with the New Jersey State Department of Health reported 24,000 admission x-ray screening examinations. Twelve per cent of persons were found to have abnormalities requiring further diagnostic examination. The case finding effort represented by the thousands of diagnostic chest films taken each year in all hospitals throughout the state has not been evaluated. Evaluation of this element of hospital service and development of routine admission programs is an evolving program.

EPIDEMIOLOGIC investigations can be undertaken only when newly discovered cases of tuberculosis are reported to health departments in accordance with the State Sanitary Code. A study of death certificates indicating tuberculosis as a primary or associated cause of death shows that approximately one-third of persons were not known to health departments as tuberculosis cases at the time of death. Study of persons discovered to have tuberculosis by case finding surveys has revealed that many cases may be unreported.

Incomplete reporting of cases of tuberculosis is a constant problem. When newly discovered cases are not reported, source cases cannot be found, contacts cannot be determined and examined, persons who require care and treatment remain undetected, and the spread of disease is not interrupted.

In recent years extensive efforts in case finding have been centered in the community x-ray survey. A well-designed educational effort, which facilitates dissemination of information concerning tuberculosis, has been essential to the success of the community survey.

Through the efforts of local health officers, tuberculosis leagues and civic groups, thousands of persons have been motivated to participate in these surveys for the detection of tuberculosis. Many persons have been conditioned to the habit of an annual examination for tuberculosis.

Early surveys were conducted in communities having an interest and willingness to plan and organize a program. Interest grew rapidly and within a short time, official and voluntary agencies were engaged in large scale efforts involving community, industrial and school populations. As the demand for community surveys grew, practical limitations of budget prompted careful evaluation of this case finding tool.

It became apparent that in many areas thousands of screening examinations were required for the detection of a single case of tuberculosis. On the other hand, in areas where mortality and morbidity rates due to tuberculosis were high, survey methods were effective in discovering new cases.

In 1957, 129,000 persons were screened in high incidence area surveys sponsored by the State Department of Health. Four per cent were found to require diagnostic evaluation. In these surveys an average of six cases of active disease were found for each 10,000 persons screened.

Between 300 to 400 thousand additional survey films may be taken in New Jersey each year. In these surveys, case finding results vary depending on the location of the survey, the age group studied, and the area incidence of infection.

DURING the past year the public has been alarmed by reports and statements concerning radiation and the safety of chest x-rays. This alarm and concern are tangible and have affected participation in tuberculosis case finding efforts even in areas of high incidence.

The basic facts concerning radiation and the safeguards necessary to protect technicians and patients are well-known to this group. In relation to tuberculosis control, the Public Health Service has indicated that a mass chest x-ray survey is a fundamental technic in the detection of tuberculosis, to be applied selectively to groups having a high risk of tuberculosis infection.

Present problems include a precise definition of areas of high incidence within the state and development of a reasonable and effective educational program to overcome fear

and confusion concerning the use and effect of x-ray examinations.

The tuberculin test by which sensitivity to the protein of tuberculosis is determined is a highly specific, long established, safe, effective procedure that is simply and economically applied. Interest in tuberculin testing on a broad base is growing as it provides the soundest epidemiological base for tuberculosis control.

By the use of the tuberculin test on a broad scale, infection rates can be determined for specific areas of the state, county, city, or section of a city. Rates of this type will permit precise definition of areas of high incidence requiring intensive control efforts. In like fashion, in areas of low tuberculosis case prevalence, tuberculin studies may be used to measure the extent of community protection achieved.

Recent study of 120,000 naval recruits and college students between 17 and 20 years of age revealed that 9 per cent were positive.[1] This finding (which demonstrates the effect of exposure to tuberculosis and infection over a period of 20 years) may be interpreted to reveal an average annual infection rate of 5 per thousand.

TUBERCULIN testing in a community makes possible the identification of individuals showing evidence of past or present infection. These persons are the most likely to develop active clinical lesions. Well-planned follow-up studies of tuberculin positive persons and their contacts appear to be a means for assuring effective case finding, early diagnosis and prompt medical care of infected persons.

New anti-tuberculosis medications have reduced the need for prolonged hospitalization. Substantial amounts of chemotherapy at home as a supplement to hospitalization are being emphasized. While care of tuberculous patients in the home is increasingly more acceptable and efficient, there is also need for well-planned medical and public health supervision of the non-hospitalized patient.

The Public Health Service recently evaluated supervision of non-hospitalized tuberculosis cases.[2] Fifty-six per cent of known significant cases of tuberculosis patients were not hospitalized. Almost one-fourth of active and presumed active cases were under no known medical supervision. No bacteriologic examinations were available for half of the active cases at home for the preceding six months, even though a substantial proportion of cases were positive when last examined.

Evaluation of case register information in one city of this state has revealed that over 1,000 cases were carried in the current register. More than 900 were *not* hospitalized, thus requiring some degree of public health supervision. One hundred and thirty-seven of these cases were last reported as having active disease. Sputum status was unknown or had not been studied in 25 per cent of active cases. In addition, 26 per cent of active cases had not had a sputum examination in 12 months. Essentially, the sputum status of one-half of the active cases was not recorded. Another fact worthy of consideration is that 40 per cent of the active cases recorded were not examined within the past year.

FUTURE OBJECTIVES

1. The relative stable incidence of new active tuberculosis and the high proportion of moderate and far advanced lesions indicate the need for a vigorous case finding effort to be carried out by the physicians, hospitals and public health agencies of the state. This effort should be directed toward the earlier detection of minimal active tuberculous lesions. All methods of screening, tuberculin, x-ray and laboratory examinations may be judiciously used depending upon the population to be screened and the area incidence of infection.

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1. Palmer, C. E., Krohn, E. F., Ma nos, N. E. and Edwards, L. B.: Tuberculin Sensitivity of Young Adults in the United States. Public Health Reports, 71:633 (July 1956).

2. Anderson, R. J., Sauer, H. I., Smith, V. B. and Roberts, D. E.: The Nonhospitalized Tuberculosis Patient. Public Health Reports, 71:888 (September 1956).

2. While tuberculosis detection efforts should include all age groups priority efforts are indicated in age groups over 45 years. In the younger age groups in which the incidence of active lesions is low there is also need for case finding activity. In this group the use of tuberculin as a screening agent is indicated to reveal those persons most likely to have clinical lesions and to obviate unnecessary examinations for tuberculosis among those who show no effective evidence of present or past infection.

3. In the large cities of the state, a relatively stable incidence of active tuberculosis, the severity of lesions, and the repeated demonstration of areas of high incidence justify the continued use of properly controlled mass chest x-ray surveys. In these cities carefully controlled tuberculin surveys are indicated to more clearly define the areas of high incidence and the extent of the population at risk.

4. The limitations imposed upon tuberculosis control activity by inadequate case reporting emphasizes the need that in accordance with the State Sanitary Code all physicians report cases of tuberculosis immediately upon diagnosis.

5. Tuberculosis case registers (which record tuberculosis cases as they are reported and the changes in status of cases as they occur) provide valuable information on the prevalence of infection in a community and the efficiency of supervision of known cases. There is indicated need for tuberculosis case registers in each county in this state.

6. Tuberculosis continues as a major communicable disease problem. Its virtual eradication is a future objective which may be achieved progressively by a continuous application of principles of epidemiology, prevention, medical care and public health, and the cooperative efforts of all the physicians and personnel of public health agencies of this state.

The State House

Eligibility for National Cancer Institute

For physicians interested in referring patients for study at the Clinical Center of the National Institutes of Health, Bethesda, Maryland, the following information is provided.

Letters of referral should include an adequate history. A full report of findings will be furnished the referring physician when an accepted patient is discharged back to his care.

The National Cancer Institute has particular interest in patients with the following diagnoses:

Acute leukemia, any age; Hodgkin's disease without previous therapy; multiple basal cell cancers of the skin; myeloid metaplasia; protein disturbances such as macroglobulinemia, cryoglobulinemia, and idiopathic hypoalbuminemia; cancer of any type in children; choriocarcinoma.

As candidates for radiologic study and treatment patients in the following categories will be considered:

Invasive carcinoma of the urinary bladder without bony or extra-pelvic metastases and without previous external extra-vesical surgery; squamous cell carcinoma of the oropharyngeal and laryngeal cavities; carcinoma of the esophagus without metastases to neck or liver; carcinoma of thyroid; solitary myeloma; chondrosarcoma.

Inquiries and applications should be directed to the National Cancer Institute, National Institutes of Health, Bethesda 14, Maryland.

William M. Dawson, M.D.
William H. Ainslie, M.D.
Metuchen

Twin Pregnancy in a Uterus Didelphys

A Case Report

Twins are rare. To have a pair of twins, each in its own private uterus is still more rare. And to have them survive birth is most extraordinary. Here is such a case.

Congenital anomalies arising from abnormal development or fusion of the mullerian ducts have long been of interest to obstetricians and gynecologists. Such anomalies often lead to interesting, and at times, serious problems in diagnosis and obstetrical management. Uterus bicornis and uterus didelphys do not present serious problems in conception, but they are often associated with abortion or premature labor. In Miller's series [1] in 1922, only 61 per cent of such pregnancies went to term. Much rarer is the incidence of twin pregnancies in such anomalies. A case of twin pregnancy occupying each half of a uterus didelphys is reported below.

A 22-year old girl, gravida one, para O-O-O-O, was first seen on March 1, 1957. Her last menstrual period had been on January 9, 1957, and her expected date of confinement was October 16, 1957. Past history was noncontributory, and examination revealed no apparent abnormalities. Her antenatal course was uneventful until July 3, 1957, when abdominal palpation revealed the probable presence of a twin gestation and "double" uterus. This was determined by the presence of a vertical midline groove on the uterus, giving a more or less irregular "U" effect, with a distinct fetal heart in each limb of the "U." These findings were confirmed on July 24, and x-ray pelvimetry was ordered to evaluate fetal size, since the possibility of superfetation was considered after abdominal palpation revealed a seemingly much smaller fetus in the right uterus. Pelvimetry demonstrated only a twin pregnancy with each fetus much below term in size (as was to be expected at this date) but no significant difference in fetal sizes. The pelvis appeared to be of gynecoid type with ample dimensions.

The patient went into labor spontaneously at 32 weeks of gestation on August 22, 1957. After a combined first and second stage of two hours (and ten minutes following spontaneous rupture of the membranes) the first twin was delivered by the modified Ritgen maneuver. After spontaneous rotation of the vertex from the ROP to the OA position, a living male infant weighing 50 ounces was delivered from the right uterus. The placenta was expressed spontaneously five minutes later and appeared to be intact. At this time, the cervix of the left uterus could be made out and was fully effaced and 4 centimeters dilated, with bulging membranes which were ruptured artificially. Contractions continued irregularly and weakly in the left uterus, and there was a tendency for relaxation and excessive bleeding from the right uterus. Consequently, an infusion of U.S.P. oxytocin 1 to 1000 was begun with good results, and the second twin, a living male infant weighing 57 ounces, was delivered from the left uterus by the modified Ritgen maneuver following spontaneous rotation of the vertex from the LOA to the OA position. The intact placenta was expressed five minutes later. Subsequent bleeding was minimal and the patient's postpartum and puerperal course was uneventful. Both infants survived.

SUMMARY

1. A case is reported of double ovum twins, each twin residing in a separate half of a uterus didelphys.

2. This complication is commonly associated, as in the case presented, with premature termination of pregnancy.

3. The management of labor and delivery in such a case is illustrated, together with the advantages to be accrued by antenatal diagnosis.

1. Reported by Eastman, Carl in Annals of North American Obstetrics, 17:492 (March 1932).

73 Amboy Avenue

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Harold A. Kazmann, M.D.

Chang You Wu, M.D.

Asbury Park

Surgical Complications in a Community Hospital*

With Particular Reference to Wound Infections

The antibiotic age has not meant the end of postoperative infections. Indeed, as the authors here point out, routine use of "prophylactic" antibiotics may permit development of more resistant strains of bacteria.

It is difficult for the individual surgeon to appreciate overall morbidity and mortality. In discussion, he is likely to remember a month in which an infection, a case of pneumonia, or the death of a severely debilitated patient occurred. Most studies of morbidity and mortality are remarkably specific. They are concerned with a particular procedure or disease or are detailed reports of a particular complication. These can be produced only in large centers where the volume provides vast clinical experience. While of great value, they give a necessarily limited view of the problem of morbidity in general.

This study was undertaken, as part of our surgical residency program, to correlate the experiences of our surgical staff, thus incorporating the individual approach with the relative volume so necessary to any study. One objective was and is the practical one of evaluating surgical risk on an individual basis.

Two hazards affect the risk of surgery in the elective case; improper preparation for anesthesia and improper preparation for the operation itself. Previous chronic respiratory disease, cardiac arrhythmia, congestive failure, angina or infarct require recognition, evaluation and specific preparation. Previous treatment with hypotensive agents or adrenal steroids must be recognized. Metabolic diseases, extreme apprehension, blood volume alterations, fluid and electrolyte deficits and the presence of food in the stomach all require consideration and correction.

In preparation for emergency operation, the important considerations are emptying the stomach, premedication, and insuring an adequate airway.

The present study began in January, 1957, after several short trial periods in the previous year. On the ward service, where a good measure of supervision was possible, an effort was made to search for all complications, even the trivial ones. The mortality includes the entire general surgical service, chiefly for the sake of comparison. Infections on the private serv-

*Read before the Section on Surgery, Annual Meeting of The Medical Society of New Jersey, May 21, 1958.

We wish to express our appreciation to Dr. Harold R. Hennessey of the staff of The American College of Surgeons for his suggestions and encouragement in carrying out this study; also to Miss Adelaide Paterno, M.T., B.A., Chief Technologist, Pathology Laboratory, Monmouth Memorial Hospital, for her aid in the bacteriologic studies. This work is from the Monmouth Memorial Hospital in Long Branch, N. J.

ice were studied with the cooperation of the attending staff.

Two forms were used. One was a *Report of Surgical Complications* to be filled out weekly on each ward or unit. The responsible house officer checked in the appropriate column. The second was the *Wound Infection Report*, filled out by the house officer (or, in private cases, by the attending surgeon) and forwarded when the infection had run its course. There were, of course, omissions, many of which were later noted in study of the mortality charts and the duplicate bacteriology reports.

RESULTS

Morbidity and Mortality—Ward Service. Fatal and non-fatal complications are summarized in Table 1. There were a total of 130 complications occurring in 54 patients. Forty of the complications occurred in the 15 patients who succumbed within 30 days of operation. Twenty-six of the complications were cardiovascular or thrombo-embolic in origin. Of particular interest are the 16 wound infections. Many were minor. Except for the purposes of the study, they would probably not have been noted. There were 9 other complications associated with infections, namely sepsis, peritonitis, sub-diaphragmatic abscess and globerulonephritis.

Fatal Complications—Ward vs. Private. These are summarized in Table 2. There were 40 ward complications in 15 patients, compared to 42 fatal complications in 29 private cases. The distribution and magnitude of operative procedures were comparable. The average ward patient was 3½ to 4 years older than the typical private patient. On the private service, average age at the time of death was 66 years and the average survival, 7.2 days following operation. On the ward service, the figures were 63 years and 10.6 days, respectively. Five of the ward patients had asso-

TABLE 1.

MORBIDITY AND MORTALITY—
WARD SERVICE

Complications	Total	Fatal
Cerebral vascular accident	4	2
Phlebitis	7	—
Femoral embolism	1	1
Cardiac tamponade	1	1
Congestive failure	5	4
Coronary thrombosis	2	—
Cardiac arrest	1	1
Pulmonary embolism	6	3
Pneumonia-pneumonitis	12	6
Wound infection	16	3
Sepsis	3	2
Dehiscence	3	2
Wound hematoma	4	—
Gastro-intestinal bleeding	1	—
Peritonitis	3	3
Intestinal obstruction	4	—
Subdiaphragmatic abscess	2	1
Ileus	11	—
Urinary retention	19	—
Transfusion reaction, minor	8	—
Transfusion reaction, major	1	1
Hepato-renal failure	2	2
Vascular shock	9	6
Glomerulo-nephritis	1	1
Electrolyte imbalance	4	1
Total	130	40

Major operations	181
Minor operations	83
Operative deaths	15

The 130 complications occurred in 54 patients.

TABLE 2.

FATAL COMPLICATIONS—
WARD vs. PRIVATE

Complications	Ward	Private
Cerebral vascular accident	2	1
Femoral embolism	1	0
Cardiac tamponade	1	0
Congestive failure	4	5
Coronary thrombosis	0	5
Cardiac arrest	1	0
Pulmonary embolism	3	2
Pneumonia-pneumonitis	6	4
Wound infection	3	3
Sepsis	2	2
Dehiscence	2	2
Peritonitis	3	5
Subdiaphragmatic abscess	1	1
Intestinal obstruction	0	1
Transfusion reaction	1	0
Hepato-renal failure	2	1
Glomerulo-nephritis	1	1
Electrolyte imbalance	1	2
Vascular shock	6	4
Cirrhosis	0	2
Thyroid storm	0	1
Total	40	42

Operative deaths, ward	15
Operative deaths, private	29

ciated neoplastic disease, as was true in 11 of the 29 private cases.

In assessing the operative deaths, pre-operative preparation could have been improved in three cases. In two cases, reconstitution of pre-operative blood volume was incomplete and in one, hyperthyroidism was insufficiently controlled. In one case each, pre-operative medication with hypotensive drugs and with steroids were probably contributory. In other cases, postoperative complications were unrecognized. In one case, there was an overlooked common bile duct stone, failure of duodenal stump closure in two, failure of colon anastomosis in one, unrecognized postoperative intestinal obstruction in one and unrecognized intra-abdominal abscess in two. In three cases, the surgery done was considerably more extensive than originally contemplated, representing a major deviation from that originally planned.

TABLE 3.

WOUND INFECTIONS

1957	Ward	Private	Total
January	1	2	3
February	3	3	6
March	1	6	7
April	1	1	2
May	0	2	2
June	2	5	7
July	0	1	1
August	1	2	3
September	2	4	6
October	1	4	5
November	3	2	5
December	1	1	2
Total infections	16	33	49
Total operations	264	1895	2159

Type of Operation	Number
Breast biopsy or mastectomy	7
Herniorrhaphy	3
Vein stripping, miscellaneous skin tumors and biopsies, skin grafts and burns	14
Thyroidectomy	5
Hysterectomy	3
Amputation	3
Cholecystectomy	5
Gastrectomy	2
Liver biopsy	1
Appendectomy	4
Colon resection following bowel preparation	2
Total	49

Wound Infections. Sixteen infections were encountered in the course of 209 clean or clean but potentially contaminated ward surgical cases. An additional 33 infections were reported from the private service. These are summarized in Table 3. The relationship between wound infections and total monthly operations varied widely. It would thus appear that infections occurred in the form of minor epidemics unrelated to season or volume. This, of course, is inconclusive in so small a series. Thirty-nine infections were subjected to bacteriologic study. These are summarized in Table 4. Clinically, three were associated with a fatal outcome but infections were not the sole complicating factor. The hemolytic staphylococcus aureus was found alone or in combination in 25 infections. Twenty were mixed infections. Sensitivity was studied by the disc method. The organism was resistant to all antibiotics on laboratory sensitivity study in 22 of the infections. In 10, it was sensitive to chloramphenicol; and in 7, to tetracycline, chlortetracycline, oxytetracycline, or erythromycin.

Of great interest was the occasional long period of clinical quiescence before a wound

TABLE 4.

SUMMARY OF BACTERIOLOGIC STUDIES

	Hospital Wound Infections	Infections Incurred Ou side Hospital	Cultures of Gall Bladder Appendix, etc.	Infe tions in Hosp. Personnel
Number studied	39	69	16	7
Mixed flora	20	63	14	0
Hemolytic Staph. Aureus	25	45	2	6
Resistant to all antibiotics	22	4	2	2
Sensitivity to:				
Penicillin	0	34	0	0
Chloramphenicol	10	29	11	6
Erythromycin, tetracyclin, chlortetracyclin	7	59	12	1

infection became manifest. This period was frequently 10 to 12 days; in one case, 21 days; and in another, 24 days. Of those noted following discharge, the greater number, were not included in the 49 infections studied. All of the patients received prophylactic antibiotics.

A particularly disquieting type of infection was the occasional furunculosis or pyoderma noted in the pre-operative or even non-surgical patient. These were not seen before the fifth hospital day and two followed pre-operative skin preparation in which operation was deferred for other reasons. These were not included in the preceding figures.

THE principal offending organism was the hemolytic staphylococcus aureus. This prompted an investigation of the mode of transmission and prevalence of the organism in the hospital. The means available were limited use of the hospital bacteriology laboratory which had not been organized for more than the ordinary clinical bacteriologic study.

The first area of study was the operating suite. This was done by exposure of standard 75 millimeter Petri dishes of blood agar for 10 minutes. The separate operating rooms, the corridors, anesthesia rooms and anesthesia equipment were included. The rooms were studied while empty with air conditioning off and on during the course of clean operative procedures. During the year, 75 cultures were made. The average colony count was 4 with sporadic counts as high as 20. In approximately a third, the colonies were hemolytic staphylococcus aureus, the remainder being staphylococcus albus, gram negative bacilli, diphtheroids, B. subtilis, molds, and non-hemolytic streptococci. Sterile packs and equipment yielded none or rare colonies. No consistent alteration in colony count was noted except for an overall increase with activity in the rooms or corridors and with the air conditioning turned on. Previous cultures of hand scrub and skin preparation were not notable in implicating either as contributing to infection.

An attempt was made to connect infections occurring in the hospital with those already established on admission. A total of 69 purulent infections were studied bacteriologically. These included infections of the ears, face, scalp, neck, back, breast, axilla, buttock, chest wall, abdominal wall, decubiti, upper and lower extremities, varicose ulcers, perirectal abscesses and pilonidal abscesses. All were mixed infections except for a few of the face and neck. The hemolytic staphylococcus aureus was present in 45 of these and non-hemolytic staphylococcus aureus in 32. In smaller numbers the following organisms were found: Pseudomonas aeruginosa, proteus vulgaris, non-hemolytic streptococcus, B. subtilis, E. coli, non-hemolytic staphylococcus albus, diphtheroids, clostridia and hemolytic streptococcus. These approximated the hospital wound infections in flora but differed in one very important aspect, their sensitivity. Only 4 were resistant to all antibiotics. Sensitivity to penicillin was noted in 34, to erythromycin in 33, to tetracycline in 21, to chloramphenicol in 15, to oxytetracycline in 13 and to dihydrostreptomycin in 3.

ANOTHER avenue of approach was the bacteriologic study of organisms found on routine culture of the appendiceal stump, opened gall bladder, colon at the time of anastomosis and ruptured colonic diverticuli. This had been carried out in 16 cases in sufficient detail to be of value. Hemolytic staphylococcus aureus was encountered in two cases, both gall bladders, one being an acute cholecystitis. The noteworthy fact was that only two cultures were resistant to all antibiotics, both cases of acute appendicitis which had clinically uneventful recoveries. Sensitivity studies were as follows: chloramphenicol, 11; dihydrostreptomycin, 9; and tetracycline and oxytetracycline, 3 each.

Infections were also encountered in hospital personnel directly concerned with the care of surgical patients. The bulk of these studies occurred over a 12-week period and involved one of the attending surgical staff, two of the house surgical staff, and four of the nursing staff. In one instance, the attending surgeon, the patient, and her private duty nurse had active infections with the hemolytic staphylo-

coccus aureus within a period of four days. The infections were carbuncles or abscesses of the face, axilla, hands and hip. Of the 7 studied, all were due to the hemolytic staphylococcus aureus with one exception, which was an axillary abscess due to non-hemolytic staphylococcus aureus. Two were resistant to all antibiotics, six were sensitive to chloramphenicol, one to erythromycin and one to tetracycline.

A few nose and throat cultures were available on hospital personnel and on patients. These were either inconclusive or open to question because of the choice of culture media. For these reasons, they have not been included.

From a bacteriologic standpoint, there are a great number of gaps. Phage typing was either not available or was not done in sufficient number to demonstrate a definite connection between the organisms encountered in the hospital and those in the wound infections. This would prove or disprove conclusively the causal connection. From an epidemiologic standpoint, there are still many other gaps.

DISCUSSION

The complications encountered are typical of the surgical procedure, age and pre-operative condition. While the ward patients tended to be older, paradoxically, the average age of those succumbing was less. Factors responsible for the higher incidence of complications on the ward are the greater age, the substantial proportion who are malnourished and the tendency to seek care late in the course of the disease. Malnourishment and undernourishment are common among ward patients due to social and economic factors. In elective ward cases, a longer time was needed to correct nutritional, blood volume and other disturbances. The tendency to seek medical care late was also evident in the patients admitted, almost *in extremis,* with long standing bowel obstruction or chronic blood loss. Apparently, acute pain and evident hemorrhage are heeded sooner.

It is not sufficient to study only operative mortality. In the hands of the overly conservative, operative mortality may be exceedingly low while patients who could have been salvaged by prompt aggressive action have been sacrificed. However, this is beyond the scope of this study and is, of course, very difficult to assess. A considerable number may be contributed by the medical services.

Because of the numerical modesty of this study, expression in percentages has been omitted as not being significant. While only surgical infections are being reported, there is no reason to believe the medical services to be immune to the same resistant infections. In the medical patient they may be an even greater danger. The recognition of the problem of resistant hospital infections and the possible causes is most important so that control steps can be instituted promptly.

Infections due to staphylococci are the cause of increasing concern, reports appearing from many parts of this country, England, Canada, and Australia. Postoperative wound infections have been reported [12] as the most common cause of morbidity on a surgical service. Incidence of infection [4] of 7.5 per cent and 10 per cent are reported.[11] Many modes of transmission and sites of origin have been implicated:[1,2,5,8,13] the naso-pharynx [6] of patients and of hospital personnel; the colon;[3] surgical scrub and skin preparation;[1] operating room air conditioning;[14] bed linen, blankets and mattresses.[6] The organism is able to remain viable for long periods of time under adverse conditions,[6] being well adapted to causing cross infections. The mechanism of acquisition of antibiotic resistance is of great importance and has been investigated by many workers.[7,9,10] Natural selection and adaptation appear to be the important factors. The fact that they are cross infections implies that they are at least partially preventable. Many of the infections were noted during the administration of prophylactic antibiotics in large doses, some becoming evident after long periods of time. None of the organisms were sensitive to the antibiotic being used at the time. This suggests that routine use of prophylactic anti-

biotics will not solve this aspect of the problem. In fact, *routine use of antibiotics may selectively permit growth of the more resistant bacteria.*

Since completion of this study, there have been improvements in the operating room air conditioning, disposal of potentially infected material and the handling of linen. This has resulted in a reduction of wound infections.

SUMMARY AND CONCLUSIONS

1. The morbidity and mortality on the ward service are higher than on the private service. The factors responsible have been outlined.

2. There is a tendency for complications to be multiple.

3. After assessing the individual's ability to cope with a procedure, there is little to be gained by deviating. The surgeon, using discretion of course, should proceed to do the operation contracted for. He should not be lured into extraneous or more extensive operations even though they appear attractive and easy.

4. The incidence of wound infections appears to be increasing.

5. Wound infections tend to occur as small epidemics.

6. There is a higher incidence of antibiotic resistance in the hospital infections although the flora of both in-hospital and out-of-hospital infections are similar.

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Patients Eligible for National Heart Institute

The federal government's Public Health Service has a "National Heart Institute" at Bethesda, Maryland. This Institute receives certain patients with heart disease, and is particularly interested in those with hormone-producing malignancies of the adrenal gland for trial of cholestenone, which is an inhibitor of adrenal steroid synthesis. Patients with post-operative recurrence of adrenal malignancy are also considered suitable for trial.

Other conditions of interest to Heart Institute investigators include:

Malignant hypertension, primary pulmonary hypertension, and cases which though sustained have had no serious cardiac, renal or cerebral complications; angina pectoris clearly associated with coronary artery disease; pheochromocytomes; adrenogenital syndrome.

For details regarding admission, send a case summary to Director, National Heart Institute, National Institutes of Health, Bethesda 14, Maryland.

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Rheumatoid Arthritis of the Feet*

A patient with rheumatoid arthritis can be treated—usually successfully—by a program including gold therapy, bed rest, salicylates, physical therapy, and general hygienic measures. Dr. Lockie and Dr. Robins furnish specific details of this program.

Arthritis may be "typed" by observation of arthritic hands. For example, the first and second metacarpal phalangeal joint and the ulnar aspect of the wrist involvement are *always* rheumatoid arthritis; while involvement of the distal phalangeal joints by Heberden's nodes, is osteoarthritis. Less well known, but almost as diagnostic are changes in the foot.

In many instances of arthritis, the foot is first involved in the arthritic process. The chief symptoms of arthritis of any joint involve stiffness, swelling, pain, heat, limitation of motion, crepitus, fatigue, atrophy, deformity and discoloration. All of these may be encountered in arthritis of the feet.

Gout, osteoarthritis and rheumatoid arthritis are the three types of arthritis most commonly seen in the feet. In making a diagnosis of *gouty arthritis*, the most important clue is the history. This is *more* important than examination of the joint. When a patient has had two or more attacks of severe throbbing pain in the joint, not necessarily the same joint, with swelling and discoloration coming out of a clear sky and lasting five days to two weeks; then subsiding to leave a perfectly good joint, that is gout and nothing else. The pain of gout is at times so severe that the jarring of the floor by someone walking in the room will cause the patient to cry out. The affected joint may look like an acute infection with swelling, discoloration and edema. The confusing thing about the diagnosis of gout of the foot, is that there often is a history of trauma while walking or playing golf which precipitated the attack. The area most often involved is the metatarsophalangeal joint. However, any of the foot joints including the ankle, may be affected. The joint is swollen, hot, reddish purple followed by a brawny desquamation of the skin on the surface. There will first be an edema of the surrounding tissue. This is acutely painful to the touch. Interestingly enough, the acute pain, when the metatarsophalangeal joint is involved, is not on the top or the bottom, but on the lateral aspect of the joint.

Osteoarthritis of the foot first may involve the metatarsal joint of a great toe. This eventually becomes the so called "hallux rigidus." There is an overgrowth of bone or exostosis which mechanically obstructs joint action. There is no swelling and no discoloration, except after prolonged standing or walking. Os-

*This work is from the Medical School of the University of Buffalo. It was read by invitation, May 20, 1958 before the Section on Rheumatism, Annual Meeting of The Medical Society of New Jersey.

teoarthritis may also occur in other joints of the feet but is mild in severity.

Rheumatoid arthritis of the feet involves the ankle, the metatarsal phalangeal joints and the phalangeal joints. The ankle is swollen and there is little motion of the joint. The patient walks in a guarded manner and at times as though he were stepping on spikes, with each step agony. The swelling is neither pitty nor spongy. If there is discoloration, the joint is somewhat red and warm, but not the hot joint of the gouty arthritic. The metatarsophalangeal joints are swollen, warm and tender. The toe joints may be drawn up in a hammer toe appearance and are tender to pressure. This involvement of the feet is usually diffuse.

RHEUMATOID arthritis of the feet is a manifestation of systemic rheumatoid arthritis and should be so treated. It is necessary that all patients undergo a thorough study. This entails a detailed history, complete physical examination and laboratory studies. X-rays are helpful. After complete studies are done, it is then necessary to take the patient into the physician's confidence, to sit down with him and discuss all facets of treatment, the seriousness of his disease and what can be expected from treatment.

It is our custom to put the patient at complete bed rest in a hospital for three weeks of intensive treatment and education, followed by several months of weekly visits to the office or home. This, in turn, is followed by additional months of less frequent visits. As for bed rest, we use three weeks as a tentative rest period, the patient must avoid all weight bearing until all pain and swelling have subsided, and he is able to move joints freely without difficulty. While in bed, the feet are kept in the optimum position—that is at right angles to the legs by a foot rest or foot board at the end of the bed which is well padded and will keep the covers from pressing on the feet. What we usually do is to place a pillow between the foot board and the patient's feet so that there is no flattening of the foot. If necessary sand bags or pillows are placed alongside the feet to prevent external rotation. In some cases it may be wise to apply a light cast coming well up over the ankle of each foot. This cast is bivalved and the posterior half is used as a splint. The splints are removed so that the ankle and toes are put through a full range of motion actively three times a day by the patient. While in bed, if the knees are involved, we must be adamant in not allowing the patient to put pillows under his knees. Radiant heat in the form of dry or moist heat is applied at least once daily. In going through full range of motion, the patient goes through set exercises such as inversion and eversion of the ankle, rolling motion of the fore-foot, flexion of the toes. Passive exercises are forbidden in the acute arthridites of the feet. Massage and exercise of the legs are necessary to maintain muscle tone while in bed. When the acute inflammation and pain subside the patient is allowed out of bed. He must wear shoes with firm soles and fairly stiff counter, no slippers. This is to support muscles and ligaments weakened by bed rest.

IF DEFORMITIES are present, a properly constructed support should be used. This is of soft cork or sponge rubber at first, with no attempted correction. The patient must continue to receive physical therapy. This may include whirlpool baths as well as exercises. Massage is never used to the painful, swollen joint. It is sometimes necessary when a patient is first allowed out of bed to use a cane to maintain balance and to help in the support of the weight of his body. At times it is good to use crutches to put joints through the normal motion of walking without bearing total weight. The extra support by cane or crutches is abandoned as soon as the gait pattern improves and the joints return to normal.

Before discharge from the hospital the complete program of exercises and heat must be outlined in detail by a physical therapist. The patient then follows a modified hospital program at home and gradually returns to normal activity.

The systemic treatment of rheumatoid arthritis must include drug therapy. Salicylates

are our main-stay for pain relief in patients who have rheumatoid arthritis. Aspirin and sodium salicylate are used in dosage of 0.6 Grams four times a day. Most patients tolerate this for a long period with satisfactory pain relief and few side effects. Tolerance is not developed with continuous therapy. Salicylates are effective agents in relieving muscular stiffness, a symptom present in most patients. Most people tolerate salicylates and find them extremely helpful in the relief of their painful feet.

Analgesics. Codeine is not recommended because it produces emotional irritability and constipation. It may cause addiction to narcotics. Although codeine is an excellent analgesic and does relieve pain in rheumatoid arthritis, because of the need for prolonged drug therapy, it is not advisable. Phenylbutazone* is an effective analgesic with a much better anti-rheumatic effect than the salicylates. Maximum plasma levels are reached in a few hours after oral dosage and it is excreted gradually over a period from seven to ten days. Toxic reactions occur and in some instances death has resulted. The principal complications are edema due to sodium chloride retention, a drug rash, activation of peptic ulcers with hemorrhage and perforation, bone marrow depression with agranulocytosis and thrombocytopenia. These toxic reactions occur usually when phenylbutazone* is used in large doses over a prolonged period. Others may develop a toxic manifestation in a day or two even though small doses are ingested. Although its use in rheumatoid arthritis is not clearly defined it has been found to be of great benefit to some who derive little help from salicylates. A dose of 100 to 300 milligrams a day can usually be taken without reaction. This has given satisfactory relief to many patients in our clinic. They are watched carefully for manifestations of toxicity and if such are noted the drug is stopped.

Gold Salts: Gold salts have been used in the treatment of rheumatoid arthritis in this country for more than 25 years. Gold therapy is the most effective agent available today to stop the progression of arthritis. Recently, the records of 1093 patients who had been under a carefully supervised broad program of management at weekly intervals for a *minimum* period of three months to many years have been studied. The data have been treated statistically and the results noted below are statistically significant. There were 369 patients who received at least 300 milligrams of gold salts during treatment. Gold sodium thiomalate (Myochrysine®—Merck Sharpe and Dohme) was used routinely, although occasionally aurothioglucose (Solganal®—Schering) was substituted. In the entire group, 57 per cent enjoyed major improvement, compared to only 38 per cent in the controls. Seven per cent were not benefited.

GOLD sodium thiomalate (Myochrysine®—Merck Sharpe and Dohme) is available in a multi-dose vial, containing 50 milligrams per cubic centimeter. A 24-gauge, ¾ inch needle is used to inject the solution into the deltoid area. The intramuscular deposit is more certain and more convenient than injection in the gluteal region. Not more than one dose per week is recommended, irrespective of the zeal of the physician to expedite treatment. Most reactions to gold occur when it is given more frequently than once a week, or when large doses are given. The dosage schedule in milligrams is: 10 the first week; 20 the second week; 30 the third week; and 40 the fourth week. This dose, 40 milligrams, is given intramuscularly at weekly intervals until a total of from 500 to 750 milligrams has been administered. At this point a re-evaluation is made, following which the dose is decreased gradually or the intervals between injections lengthened. Patients eventually will be given a small dose, perhaps 10 or 20 milligrams at monthly intervals for an indefinite period, provided no toxic reaction has occurred. When the arthritis becomes inactive, chrysotherapy is discontinued.

Toxic reactions are rarely severe in the carefully observed patient. Before each injection the patient must be questioned closely concerning any possible reaction. Certain information to be obtained from urinalysis and blood count studies, collected at regular in-

*Available under the Geigy tradename of Butazolidin®.

tervals, also warns the physician if intolerance to gold salt is developing.

The most common toxic reactions involve the skin. Glossitis with the characteristic burning sensation along the edge of the tongue and stomatitis, as manifested by a metallic taste of the mucous membranes of the mouth or the feeling that soup, which is too hot, has been tasted, may appear. Occasionally thrombocytopenia and agranulopenia are noted in the blood determinations; less commonly albumin appears in the urine.

Fifty per cent of the patients who experience a reaction are able to take more gold, after an interval of from six to eight weeks, when it is administered in small doses.

THE physician must exercise caution when administering gold salts. With reasonable care, however, gold is safe to use at any age, including children. A few conditions are contraindications to the use of gold salts in any dosage: they are systemic lupus erythematosus, nephritis, blood dyscrasias and a tendency to hemorrhage.

The urine should be examined every two weeks for red blood cells and albumin. The red blood count, white blood count and blood platelet determinations are checked every four weeks. The first toxic manifestation upon blood-forming organs may be a decrease in the number of blood platelets. At other times, the granular series of white blood cells may be affected. Any decrease from the normal implies immediate cessation of gold salt injections. However, patients have been seen who have had a drop in the number of blood platelets and later have been able to tolerate small doses of gold with improvement in symptoms. A few patients have experienced a marked reaction to the first or second dose of gold; if this is observed, however, it is important that gold be stopped and not resumed.

The results of treatment of patients with gold are most satisfactory. It is a potent suppressive agent as far as the progression of the disease is concerned and is widely employed throughout the United States. We do not know its mode of action. The closer the patient is to a toxic reaction, no matter how mild, the more marked the improvement. Gold salts are an important adjunct in the management of a patient with rheumatoid arthritis of the feet.

Steroids: Adrenocorticosteroids and ACTH have been responsible for a tremendous interest in research in the field of rheumatology since 1949. These agents do not correct the underlying process in rheumatoid arthritis. Their effect is suppressive. Many patients need some steroid medication from time to time in the course of their disease. It must be carefully supervised at all times. The patient is warned not to try to go beyond his physical limitations, even though he may feel well due to the steroids. The signs and symptoms can be relieved markedly but only temporarily. Favorable changes occur in the synovial fluid as well as in synovial tissue, with changes toward normal in the blood count and blood chemical findings during administration.

Here are our indications for steroid therapy.

1. When the clinical status is discouraging to the patient and to the physician, despite faithful adherence to a carefully planned program. In such a situation steroids are used in a dosage adjusted as low as possible in order to give partial relief of symptoms. If the relief were 100 per cent, the dosage would be too high, and the development of side effects would be marked. The dosage is individual for each patient and must be adjusted each week or two by the physician. The patient should not be permitted to stay on a given dose for more than two weeks at a time and also should not have control of his own dosage. Every effort is made to decrease the steroids when not necessary for symptomatic relief. If side effects develop from small doses, steroids should be discontinued immediately.

2. Some patients have short-term exacerbations. This is especially true of juveniles suffering from rheumatoid arthritis. They should be given a corticosteroid during the course of the flare-up. It is discontinued gradually as improvement permits.

3. Patients who experience severe constitutional symptoms, such as tachycardia, pericarditis and high fever, need steroids as a life-

saving measure. Some would not survive without full dosages of steroids.

4. During the rehabilitation of the patient with severe involvement, it is easier to treat the patient and demonstrate the objectives under suppressive effective steroids. It may be necessary to use the steroid for months in order to accomplish selected objectives in rehabilitation.

Corticosteroid therapy will produce the changes of Cushing's syndrome, *i.e.*, obesity, moonface, "buffalo hump," hirsutism and acne, if medication is continued long enough and in sufficiently large doses. Sodium retention is not seen as commonly with prednisone and prednisolone as it was with cortisone and ACTH. Lowered potassium blood levels are not observed with the newer preparations, but increased blood pressure and hyperglycemia occur occasionally. Inasmuch as osteoporosis is a part of the underlying pathology in rheumatoid arthritis this will worsen with long-term therapy. Vertebral collapse, a complication of osteoporosis, usually does not occur unless the corticosteroids are taken a minimum of seven months. This is a serious, painful complication and seems to develop more often in postmenopausal women.

Psychologic reactions as a result of the corticosteroid or ACTH administration vary from the mild to the severe. It is not possible to predict in which patient the changes will occur or what the severity will be. Steroids are contraindicated in the presence of psychoses and in patients with severe psychoneuroses. Two of the most disturbing complications of corticosteroid therapy in our clinic are bleeding and perforated peptic ulcer. It seems that the newer steroids such as prednisone and prednisolone are a little more likely to precipitate these complications than the older steroids. Be careful in the use of prednisone, prednisolone and related steroids in people with chronic or acute infections.

Postoperative deaths have followed surgery as the result of shock due to adrenal insufficiency. It is impossible to determine the extent of adrenal cortical insufficiency in patients who have taken steroids, nor for what period cortical insufficiency persists following cessation of administration of the drug. Therefore, it is wise to give large doses of hormones just before, during and after surgery, with gradual tapering off to prevent this irreversible shock. As a reminder, the hormones can be given orally, intramuscularly or intravenously as necessary.

It is of great help to some patients with rheumatoid arthritis of the feet, who may have one or two joints involved, to use hydrocortisone or prednisolone TBA intra-articularly. This diminishes the amount of oral or systemic corticosteroids needed to give relief.

Vaccines: Vaccines are not accepted by many rheumatologists. However, there is a strain of hemolytic streptococci which is agglutinated by the serum of adults who have rheumatoid arthritis. This agglutination may occur even when the serum is highly diluted. It is seldom found in the serum of patients suffering from other diseases. The significance of this reaction is not clearly understood, but it is an immunologic reaction of relatively high specificity. On this premise, as part of the broad plan of management, patients who are unable to tolerate gold are given a vaccine of killed hemolytic streptococcus administered weekly in small amounts of 4,000,000 organisms subcutaneously. The dosage is maintained at the same level and is not increased. There appears to be some benefit in patients who receive vaccine at weekly intervals, as compared to those who do not receive it. Also it must be appreciated that there is a psychologic factor to be considered. It must not be forgotten that this is only one of many facets which comprise the well-rounded program of treatment.

Sedation: Sedation is desirable during the hospital stay in view of the fact that most patients are in a state of apprehension. In this case a small dose of a sedative is given during the day. Occasionally a hypnotic dose is indicated at bedtime to insure a good night's sleep. Rest is so vital in our program that every effort is made to achieve it day and night. As necessary during the day a small dose of barbiturate or one of the tranquilizer drugs is prescribed. For a peaceful sleep,

pentobarbital or secobarbital is given when needed during the hospital stay. These drugs are completely metabolized over a period of from six to eight hours, thus enabling the patient to awaken in the morning refreshed. After hospital discharge, most patients do not require hypnotics regularly but may receive benefit from mild sedatives during the day for a month or two.

Iron: The degree of anemia usually parallels the severity of rheumatoid arthritis. Although the effectiveness of iron in the treatment of anemia has not been proved, it is accepted practice to prescribe either ferrous gluconate or ferrous sulfate 0.3 Grams three times daily. Ideally, the iron should be given between, not immediately after, meals. Patients who have severe anemia frequently derive benefit following transfusions with 500 cubic centimeters of whole blood weekly, for several weeks. Impressive results have been seen in some patients who suffered from severe active arthritis. The effect appears to inhibit the arthritic process, as well as to correct the anemia.

Other Factors: Climate has received considerable attention in the treatment of rheumatoid arthritis. People who are able to enjoy a warm climate with a shining sun each day feel better. Although a patient moves to a warm climate, his arthritis will still need care by a capable physician. Diet plays no part in the patient with rheumatoid arthritis, except that in any chronic disease a well balanced diet should be followed. There are no specific foods to be avoided or taken. Patients who are overweight should be reduced. In those who are underweight, an attempt should be made to maintain their nutrition.

Foci of Infection: For many years, focal infection played a prominent part in the treatment of arthritis. Foci of infection should be removed, not because this will eradicate the arthritis, but because this will help maintain a better, well-rounded general condition of health. If these foci need attention because of general health measures, then they should be treated.

SUMMARY

IN TREATING the patient with rheumatoid arthritis of the feet, it is necessary to treat the patient as a whole, because this is merely a manifestation of the systemic disease. Treatment consists of a broad specifically tailored program of management including general health measures, gold therapy, bed rest, physical therapy and medication directed toward alleviation of pain.

Excellent results can be anticipated in about 57 per cent of all patients so treated. Only 7 per cent of treated patients fail to experience some relief.

40 North Street

Histoplasmosis Cases Accepted by N. I. H.

The federal government's Department of Health, Education and Welfare operates an Infectious and Allergic Diseases Institute, just north of the city of Washington, D. C. To determine if your patient is eligible, send a case summary to the Director of the Infectious and Allergic Diseases Institute, National Institutes of Health, Bethesda 14, Maryland.

The Allergy and Infectious Diseases Institute has especial current interest in disseminated histoplasmosis. Studies include improved diagnostic methods, new therapeutic agents and basic immunology.

Sanford M. Lewis, M.D.

Newark

A Formulation for Psychosomatic Practice

Everybody is in favor of a psychosomatic approach, and all doctors want an "integrated" practice of medicine. The problem is not this obvious ideal, but rather how to accomplish it. Dr. Lewis here makes some pertinent and practical suggestions.

The approach to medical practice which attempts to integrate what is known about organic disease with what has been learned about emotional responses is known as "psychosomatic medicine." Scattered attempts to define and relate these concepts to actual clinical problems appear in the literature. They have succeeded only superficially, however, in reducing the tenacity of "either-or" (organic *vs.* neurotic) thinking, which still represents a majority attitude among practicing physicians. The term "psychosomatic" itself is regressive and self-defeating. Its use emphasizes a remarkable lack of progress since Plato's observation that " . . . this is the great error of our day . . . physicians separate the mind from the body." In several millenia, apparently, we have succeeded merely in eliminating a hyphen.

It is the purpose of this paper to attempt a broad and general perspective of the problem in practical as well as philosophical terms and to suggest possible approaches at various levels—the therapist, his hospital, and the medical community as a whole.

There is a distinct difference between intelligent, up-to-date medical practice in general and the specific area of psychosomatics. It may reasonably be required of the former that it recognize the relationships between organic lesions and emotional conflict. Therapy also might be expected to combine sympathetic objectivity with recognition of the patient's emotional as well as physical needs. Such a description, we might agree, represents the attitude of a "compleat physician" of our day. It does not, however, describe psychosomatic medicine.

If we are successfully to integrate emotional and somatic factors, we must assume an ability to understand the psychodynamics involved as well as the physiologic alterations. The internist may fully appreciate the hemodynamic changes in coronary disease and possess the latest information on metabolic relationships in atherosclerosis. He may fail, however, to understand the psychologic needs which his patient's angina are serving, or the aggressive feelings for which it represents a destructive substitute. This physician, aware that emotional factors may influence angina, but inexperienced in the means of identifying and coping with them, can qualify as a fine cardiologist. His "sympathetic reassurance," however, does not identify him also as an effective practitioner of psychosomatic medicine.

A workable definition of psychosomatic practice might approximate the following: "That approach to the management of illness

which combines identification of physiologic and psychologic pathology diagnostically, and which uses psychological as well as physical, chemical, and anatomic media therapeutically." The so-called "functional" syndrome will, of course, involve considerably more psychiatric insight than the organic lesion manifested anatomically. At both ends of the spectrum, however, there is general agreement that a significant contribution by the remote variant exists in any sick individual.

NEED FOR PSYCHOSOMATIC PRACTICE

THE rate of accumulation of psychiatric knowledge has paralleled, although somewhat less spectacularly, advances in surgical and chemotherapeutic technics. Translation of academic and laboratory advances into tools for treatment is a continuing process in centers of psychologic research. Psychiatrists are applying much more "know-how" to many more people with more consistent success. But the number of patients helped in this fashion is pitifully small. Conventional psychiatric approaches, whether diagnostic or therapeutic, are time-consuming and often expensive. The need is apparent, therefore, to supplement the efforts of doctors devoted exclusively to this field with those of others in related disciplines, and to use accepted principles in shorter less comprehensive fashion with more limited aims. An attempt at deep and total personality reorientation is desirable in many patients, although available in terms of time and economics to very few. The clinical psychiatrist makes his contribution by dealing with severe emotional disorders. He, too, is overwhelmed, and the demand for his time far exceeds the supply and will, it appears, for years to come.

What of others then? In a huge majority, psychopathology plays an important and often determinative role in the total disease picture. Yet the emotional component is often not severe enough to warrant specific psychiatric treatment. Can the family physician, the generalist, the internist manage these problems? Only, as suggested above, if the practitioner's preparation and experience in psychodynamics equals the background usually insisted upon in physiology, anatomy, and chemistry. Reassurrance and support will improve many situations superficially and temporarily. Such "first echelon" psychotherapy, together with diets and drugs, is too frequently not enough for innumerable cases of peptic ulcer, colitis, eczema, hypertension, asthma, and angina. More help, fortunately, is available. Means must be established to put it to work for the benefit of greater numbers.

Thus, the physician trained in psychosomatic medicine is adding another dimension to traditional therapeutic approaches. His value to the patient is sufficient reason for his concentration in this area; but there are also other benefits. Perhaps most important among these is the open line of communication which exists between the psychosomatic practitioner and his hospital colleagues. The psychiatrist is often involved only minimally in the general hospital organization. But the internist, generalist, or pediatrician interested in psychosomatic problems is an active participant in the medical affairs of his institution. His knowledge of psychodynamics, the methods and results of his work therefore become a matter of first-hand experience for his colleagues. In this fashion, a great body of misinformation about psychiatric principles can be dissipated. The work of the psychiatrist himself is thereby more widely understood and appreciated and his greater integration within the hospital family encouraged and expedited.

A logical outgrowth of this viewpoint is the establishment of psychosomatic services in general hospitals. Such organizations already exist in progressive institutions in New York, Philadelphia, Cincinnati, and elsewhere, and serve as models of similar programs which hopefully will be developed in local communities. The effect of this planning is to integrate the contribution of the psychiatrically trained physician with that of the organically oriented medical man and surgeon. A more comprehensive therapeutic unit is thus created with inevitable upgrading of the level of total medical practice.

THE PSYCHOSOMATIST

THE physician who, by inclination and training, becomes skillful in the application of psychodynamic principles to the problems of clinical medicine is usually, although not invariably, an internist. The "gestalt" of the medical man and his interest in the total patient situation contributes to this trend. His professional relationship with psychiatrists and his need for their consultation is perhaps greater than among other specialties.

Such association alone is not sufficient to provide the psychodynamic insights and therapeutic "know-how" which specialized psychosomatic practice requires. The former is often attained through personal experience as a subject in psychotherapy or analysis. The latter must be acquired through work in a clinic center engaged in psychosomatic and psychiatric research and treatment. Actual participation as a therapist, under the guidance and control of supervising psychiatrists, provides preparation in this area. Acquaintance with basic psychiatric literature and reasonable familiarity with current trends through periodicals and the several societies devoted to psychosomatic problems represent another essential.

PSYCHOSOMATIC PRACTICE

HIS work will involve the psychosomatist for the most part with out-patient clinic and office problems. He may also make an important contribution to in-patient medical care. Through facility in obtaining anamnestic material and in recognizing dynamically significant verbal and non-verbal clues, he learns to differentiate organically determined symptoms. Thus, he is in a position to help the treating physician pin-point the etiologies of his patient's illness. Involved and expensive laboratory study may be obviated in many cases and an integrated therapeutic plan more readily devised. Graphic demonstration to house-staffs of the role of psychogenic determinants in disease represents one of the important values of such a program on any teaching service.

In the out-patient clinic and office, details of conventional history, physical examination, and laboratory studies are usually supplied by the referring physician. The psychosomatist uses his medical background to augment these data where necessary. Re-examination of those areas where such emphasis seems important helps to cope with the patient's anxiety. The physician is equipped also to make observations of psychodynamic variations and to measure their impact on the manifest symptomatology. Where such pathology is severe and deep-rooted, he may refer the case for psychiatric management. Where the organic factors predominate, he may be in a position to counsel the referring agency as how best to manage the anxiety which almost inevitably accompanies illness. When evaluation of new forms of treatment is undertaken by a specialty clinic, he may be able to aid significantly in identifying reactions which are psychogenically rather than pharmacologically induced. The author's experience with psychosomatic interviews in a series of angina cases (to be reported elsewhere) convinces him that no "double-blind" or similar statistical technic alone can adequately evaluate drug therapy where results depend eventually on the subjective response of patients.

The hypertensive, the asthmatic, the patient with peptic ulcer, colitis, and migraine, who fails to respond adequately to diet, medication, and reassurance may become a candidate for psychotherapy on a regular basis. Management of incapacitating anxiety, working through of situational problems, and acquisition of some insights into motivation and reaction patterns may all be accomplished in this manner. A level of relief may thus be obtained without unduly prolonged or penetrating investigation. Limited aims and limited duration of therapy will result in more cases treated, and the psychosomatist will have sufficient time to retain the necessary balance in his practice between hours devoted to conventional medical duties and those segregated for psychotherapeutic sessions.

The more deep-seated mechanisms of archaic libidinal needs, the Oedipal conflict, the transference situation rarely become part of

such an approach. Interpretation is minimal. The primary requisite of a psychosomatic practitioner, as in every other field, is that he recognize his limitations and the limitations of his methods. Periodic discussion of his cases with a psychiatrist or analyst is a rewarding means of insuring proper formulation and direction of therapy.

CONCLUSIONS

LIMITATIONS of space make it impossible to review here the psychosomatic examination and interview, the therapeutic session, the education of a psychosomatist, and the organization of a psychosomatic service. At present, it may be sufficient to suggest that a need for increasing the depth and maturity of medical practice has resulted in the evolution of a new approach. This attempts to integrate what is known about psychodynamics with that which is familiar in physical, chemical, and anatomic terms.

Psychosomatic medicine is, hopefully, a self-liquidating entity. As more and more of the graduates of our medical colleges become indoctrinated by training in psychiatric as well as organic principles, and as the value of such orientation becomes appreciated by increasing numbers of practicing physicians in all fields, the necessity for a special subdivision concerned with this integration will become progressively less compelling. For the present and for some time to come, however, it appears more than likely that Psychosomatic Medicine, as a philosophical concept and as a specific approach to disease, will make an important and constructive contribution to medical progress.

88 Chancellor Avenue

Free Play in Pregnancy

"I allow my patients to do anything," says Dr. Alan F. Guttmacher in discussing the management of his own patients during pregnancy. Dr. Guttmacher is director of Obstetrics at Mount Sinai Hospital, New York City.

There is no athletic event, even skiing and horseback riding, that Dr. Guttmacher forbids pregnant patients so long as there are no complications.

Dr. Guttmacher's patients are encouraged to continue their jobs and to go out socially. He thinks a woman should be a participant, not a bystander to the events of her pregnancy; and that the physician's management of emotional factors can help make pregnancy a rich and memorable experience. He says: "Our function as physicians is to make pregnancy as happy and full an experience as possible."

Asked what pregnant women worry about most, Dr. Guttmacher said, "Fear of death, fear of pain and fear of having an abnormal child." The doctor has excellent ammunition with which to deal with the fear of death. "Today, we can honestly tell our patients that less than 1 woman in 2000 dies in the process of childbirth."

As to pain relief, Dr Guttmacher says that, unlike other countries, "In America there is a great demand for pain relief. The American woman wants it, she demands it and she gets it . . . In the hands of an expert I don't think drugs are prejudicial."

With regard to the fear of bearing an abnormal child, Dr. Guttmacher believes in putting the facts squarely before the patient and assuring her that the odds are "gigantically" in favor of her having a normal baby. "I would like to point out that whatever the patient's fears, the physician should be careful not to take a moralistic or punitive attitude. The knowledge of mind and body which has accumulated over the years means a great deal to her . . . at Mt. Sinai, we have a psychosomatic clinic in obstetrics . . . We constantly stress the importance of the psyche in pregnant women."

Trustees' Meeting: September 21, 1958

The President announced he had appointed Dr. John D. Preece as representative of our Society to a workshop at Rutgers on the nurse's role in childbirth. Dr. Ralph Buchanan was designated to attend the American Medical Association Conference on Medical Society Action in Geriatrics held in Chicago in mid-September. Dr. Vincent Mahoney was named to participate in the hearing before the New Jersey State Commission on Mental Health on the problem of determining responsibility for the maintenance, care and education of mentally retarded and mentally disturbed patients. Dr. John J. Torppey will represent the Society during the Diabetes Detection Drive. Dr. Robert E. Jennings was named as the Society representative to the State Department of Education. All these appointments were made by the President and ratified by the Trustees at the September session.

The Trustees designated Dr. Willis R. Mitchell to attend the American Medical Association Conference on Industrial Health to be held in Cincinnati next February.

A special committee was appointed to investigate possible retirement plans for physicians. Dr. J. G. Kaufman was designated Chairman. The other members of the committee are Dr. N. E. Marchione of Vineland and Dr. A. E. Moriconi of Trenton.

The Board of Trustees received a suggestion from a New York company specializing in survey and consulting service to professional organizations. They proposed to study the administrative operations of The Medical Society of New Jersey and make recommendations for improvement. It was estimated that a complete survey would cost from $10,000 to $15,000. Such surveys have been made for medical societies in several other states.

The Board voted not to avail itself of the services offered.

There was some discussion as to whether the Medical Society should be a party to a counter-suit by a physician against a plaintiff who had charged him with malpractice. The court dismissed the action as without foundation. The physician, desiring vindication intends to sue the plaintiff under the terms of the current law permitting such suits. A special committee was appointed to study the matter and bring in a report as to whether the Medical Society should participate. To this committee was appointed Dr. Ralph Buchanan as Chairman and Drs. Wegryn and Schretzmann. The Trustees endorsed in principle the development of a new Diet Manual to be prepared by the New Jersey Dietetic Association and the State Department of Health.

The Secretary reported on a number of resolutions which have been received in response to action taken by the 1958 House of Delegates. These included proposals to increase medical fees and hospitalization limits under Blue Cross and Blue Shield. Some of the resolutions also concerned methods of adjusting the subscriber's entitlement to service benefits to fit the subscriber's changing financial position. A communication was also received about the complicated forms required in the preparation of reports to Medicare.

A report was read from the special committee on house maintenance, staff policies and personnel relations which had prepared an organization chart outlining duties of the department heads. This chart was endorsed by the Trustees who recommended that it be adopted and used as a basis for operations for a one-year trial period. Under this plan each one of the Department Heads would have an Advisor. To the Editor the Advisor would be the President-Elect. For the Executive Officer the Advisor would be the President. For the Building Superintendent the Advisor would be the Chairmen of the Committee on House Maintenance and of the Board of Trustees. Mrs. Madden will continue as Building Superintendent. It was also decided that those contracts connected with the maintenance of the building be approved by the Committee on House Maintenance.

The Trustees considered certain aspects of Medicare and approved recommendations to the effect:

(1) That Medicare administration continue through its special committee and through the Medical Service Administration.

(2) That the Board rescind the action of the Executive Committee in the letter to Medical Service Administration dated September 12, 1958.

(3) That the Society not interest itself in securing an indemnity plan for Medicare.

The Board rejected the proposal that atten-

tion be given to the advisability of using an unpublished fee schedule.

The President and the Secretary were authorized to sign a surety bond to support the Medicare program. The contract renewal was also reaffirmed.

The Trustees authorized the Committee on Medical-Legal Testimony to draft a code of cooperation between the two professions.

The Trustees approved a plan of conducting a one-day Institute for public relations in New Jersey this year.

There was discussion of the practice of certain laboratories in other states soliciting business from New Jersey doctors by offering for a fixed amount per month to do all the doctor's laboratory work.

The State Board of Medical Examiners considered such laboratories unlicensed and their solicitation of this work unethical. However, the State Board of Medical Examiners has no jurisdiction over laboratories outside of the state. The Trustees voted to refer to the Judicial Council this matter with the suggestion that the State Boards of Medical Examiners in the home states of these laboratories be notified.

The Trustees then heard the report of the Committee on Legislation and took the following positions:

A-520: To impose a net income tax on corporations. No action.

Intravenous medication by nurses: Approved a proposed amendment to give legal protection to nurses who give intravenous medication in hospitals.

Physical examination of school children: Approved a change in the statute which would allow examination of a pupil by any licensed physician to be accepted by the medical inspector of the school in lieu of his own examination.

The Trustees authorized transfer to the Medical Student Loan Fund of the sum of $5382 realized as a balance of receipts over expenses of the 1958 Annual Meeting.

The Trustees decided that only two afternoon scientific sessions will be held during the 1959 Annual Meeting. There will be no scientific programs scheduled for evening sessions. All evenings will be free for personal and social activities at the 1959 Annual Meeting.

At the request of Governor Meyner, the Board of Trustees submitted to the Governor three names for possible appointment to the State Board of Medical Examiners.

The Board approved the nomination of Dr. Samuel J. Lloyd and Dr. Charles L. Cunniff to the Board of Medical-Surgical Plan.

The Trustees referred to the Judicial Council an inquiry from the Editor of THE JOURNAL whether THE JOURNAL should accept advertisements from members who offer x-ray diagnostic and skin diagnostic service to other members of the Society or whether such advertisements should be considered unethical.

The Trustees authorized the following to attend the American Medical Association Clinical Meeting in Minneapolis in December: The President, President-Elect, Secretary, Executive Officer, and one Alternate Delegate.

The Trustees approved a request from Dr. Allman that this Society sponsor a dinner in honor of the officers of the American Medical Association during that organization's convention in Atlantic City in June 1959.

Patients Who Have Ingested Radium

A study by the New Jersey Department of Health may influence recommendations and standards for determining how much radioactive material a human being can tolerate.

The present maximum permissible limits were set by the Atomic Energy Commission, the United States Public Health Service, and the National Commission on Radiation Protection. These limits are tentative. There simply has not been enough longtime experience on which to base them.

The original limits were set in 1940. Judgment was based on a small number of selected cases. The complete identification of and the concentrations of radioactive materials in the body were not definitely established. There was uncertainty about the relationship between the effects noticed and the identity of the causative radioactive material, as to whether they were due to radium or mesothorium or a mixture of both.

The current study of the New Jersey State Department of Health is a basic research project to determine the chronic effects of radium ingestion on humans. The contract under which it is being carried out is the first ever

granted by the A.E.C. to any state department of health. The persons to be studied are ex-employees of industrial plants which used radium in their work. Most of them worked 35 to 40 years ago. Some painted watch hands and dial faces with a paint which contained radium. In so doing, many of these persons placed in their mouths the brushes which were used in painting the dials. Others prepared the paint, conducted experiments with it, or otherwise had contact with the material. About 800 persons in these several categories worked in the larger companies in New Jersey. There were another 100 to 200 in smaller industries in New Jersey or New York.

Whatever the method of exposure, these persons constitute the largest pool of chronic radiation exposed people in the United States, possibly in the world. They have been living, in some instances, for at least a generation since exposure. Some of them have children and grandchildren. There are some smaller groups in other states in this country. No other group even approaches the concentration in New Jersey.

Dr. Daniel Bergsma, New Jersey State Commissioner of Health, says that "if this group were not studied in this manner, there would be lost a significant amount of information about the latent effects of radiation which is not available elsewhere in the world at this time to our knowledge."

If you treated any such patients you may be able to make a significant contribution to this study.

The Atomic Energy Commission is primarily attempting to determine a relationship between the concentration of radium retained in the body for long periods of time and the effects of this body burden upon the individual.

When these studies are completed, we will have information about radium and its effects and, hence, the effects of other radioisotopes. If we have knowledge of the biologic effects of a given concentration on one radioactive material, we can estimate the relative hazards of other radioisotopes.

The New Jersey project is being carried out in four steps. These are:

1. Identification of and search for the present location of all of the former employees of the radium industry.
2. A personal interview and follow-up to obtain a family and occupational history.
3. Medical studies to obtain information about effects of the radiation upon the individual.
4. Radiation studies to obtain information about the identification of and concentration of radioactive materials retained in the individual.

There are many other persons unknown to the Department now who can make a significant contribution to our research if they will but participate in this study. They will not be exploited or subjected to any personal publicity on the part of the New Jersey State Department of Health. All information will be considered privileged and will not be divulged without prior written permisssion of the individual concerned.

Physicians, dentists, and staff of hospitals who may have seen, treated or examined any persons formerly employed in the radium industry are urged to communicate with:

Mr. Lester A. Barrer
Radiological Health Program
State House, Trenton, New Jersey
Telephone: EXport 2-2131, Extension 8282.

Any Photos of Your Ancient Car?

The Illinois Medical Society is preparing an exhibit on the role of physicians in the development of the automobile in the United States at the turn of the century. They would appreciate the loan of old photographs showing physicians at the wheels of cars prior to 1912. Scenes showing difficulties on the road, or poor highway conditions, are especially desired. Enlargements will be made and the originals will be returned undamaged.

Photographs should be accompanied by a memo giving the name and town of the physician, whether living or deceased, and the make and year of the automobile. They should be sent to Mr. John A. Mirt, State Medical Society, 185 North Wabash Avenue, Chicago 1, Illinois.

Open Discussion on Medical-Surgical Plan

192nd Annual Meeting

May 17, 1958

The discussion on the Medical Service Administration and the Medical-Surgical Plan of New Jersey was convened at 4:05 p.m., Dr. Royal A. Schaaf presiding.

Dr. Schaaf: Good afternoon, Ladies and Gentlemen, and welcome to the annual session on the discussion of the Medical Service Administration and the Medical-Surgical Plan of New Jersey. Before proceeding I would like to present some of our staff and some of our associates. I will ask Mrs. Nugent to take a bow. She is the Administrative Secretary of the Medical Service Administration and has done a wonderful job for us. (Applause)

And here is Mrs. Jennings, who has been with the Plan since its inception in 1942 and has done a tremendous job and continues to do a good job. (Applause)

And there is Mr. Robinson, Administrator of the Plan. He is responsible for the supervision of much of our administrative work. (Applause)

Here are Mr. and Mrs. Zotty. Mrs. Zotty has been a fellow worker in the Plan for a great many years. She left us rather recently to assume the duties of the household. Mrs. Zotty. (Applause)

Here is a man who has done a tremendous job in the development of the Medical-Surgical Plan of New Jersey. As Vice-President of the Hospital Service Plan of New Jersey, he was the sole, principal officer engaged in our work until a few years ago, and his contribution to our development and welfare has been enormous. It's my pleasure to introduce Mr. J. Albert Durgom. (Applause)

Now, running down the line, the rest of the members, except one, are members of our medical staff. First is Dr. Nicholas Alfano, who is the Medical Director. (Applause) Dr. Harry Commando, who is in charge of our physicians' relations work: Dr. Irving P. Borsher, consultant to the Plan, who has been its long time Medical Director. Next Mr. William Vanderbilt, son of the former Chief Justice Vanderbilt, counsel to the Plan. (Applause) Next comes Dr. Kimmell, Associate Medical Director; Dr. Rothgesser, Associate Medical Director; and Dr. Nacca, who is the Assistant Medical Director.

I am not going to call the roll of the Trustees. There are many of them in the audience. You all know them, and we will consider them thanked without any special recognition from the platform.

Among the more interesting points in our report are the number of claims handled by the Administration and the great change in the unit cost of administering claims. It fell from $11.44 during the first six months of 1957 to $2.32 in the second half and since. It represents a great increase in efficiency and, as a Board, we are quite pleased with this progress.

The Medicare program, we hope, will be continued. If it is continued, we hope that the Medical Service Administration will continue to handle it.

In the report of the Medical-Surgical Plan, you will notice some interesting items which relate to various technical aspects, a comparative statement of income and growth, a comparative summary of operations, a summary of reserves, highlights of Plan operations, plans incurred, claim incidence and annual statistics for 1957.

I'd like to dwell for a moment on the question of reserves at December 31, 1957. A resolution was introduced this afternoon in regard to the establishment of a retirement plan for members of The Medical Society of New Jersey. It was recommended that the Medical-Surgical Plan make substantial contributions to such a fund. This suggestion gives an opportunity to open the discussion about what seems to be a very large reserve. At the end of December 1957 we had three million dollars more in the treasury than we had at the end of December 1956. This is very deceptive. It has deceived other people than the doctors. The large reserves are only temporary and incidental. They are incidental to the establishment of the distribution of the 1956 contract and we have not yet picked up the maximum demands which will be made under this contract.

When the maximum demands reach their peak (as they will sometime toward the end of the second year) this very creditable reserve is going to be sharply diminished. The likelihood is that at the end of the third trial year we will be impairing our reserves and

getting down to an acceptable but not excessive level. This has important bearing on what action is recommended by the Reference Committee in relation to this proposal for a relief fund.

The doctors have no vested interest in the resources of the Medical-Surgical Plan of New Jersey. These resources belong to the subscribers. The Board has no moral right to make a donation to a retirement fund for physicians. We have no legal right to do it and we would unquestionably encounter a ban against it by the Department of Banking and Insurance. We offer that to show that sometimes we go off on a tangent. It is a wonderful thing to have a retirement plan for doctors; but it couldn't possibly be set up under the aegis of or by the contributions from the Medical-Surgical Plan of New Jersey.

Three years ago this House of Delegates urged our Board to make certain additional benefits available under any new contract. Under the 1956 contract we accomplished as many of the desired objectives as was possible to induce the Department of Banking and Insurance to approve. We subsequently have been working on riders. A year ago we finally got the consent of the Department to the offering of riders on a tentative basis. The statement then was that we had no reliable actuarial data for the computation of a rate. This objection was ultimately overcome and we are presently working industriously on the development of our riders.

One rider which will probably be approved by the Banking Department is an increase in the number of medical days in hospital to parallel the number available now under the Hospital Plan contract. Another is the extension of surgical procedures in out-patient departments and physicians' offices. A third one would be radiation therapy for proved malignancies in the private office of the radiologist. We are now studying two others. One relates to the offering of payment for clinical pathological service outside of hospital and for diagnostic x-ray service out of hospital. These are difficult to compute from the actuarial standpoint and we may have trouble getting those two approved by the Banking Department. Note that the proposal to add pathology service and diagnostic x-ray service is limited to those services when rendered out of hospital. The situation for the payment of pathologists, and radiologists by the hospitals is so complex that we couldn't possibly cope with it on an in-hospital basis. Furthermore, that would represent an invasion by hospitals or an extension of the invasion by hospitals of the private practice of medicine. So that we have come up with a proposal to limit these to services out of hospital; x-ray diagnostic service to be limited to a hundred dollars a contract year, and pathology service to $25 for a contract year. These are both desirable but they may encounter the opposition of the Banking Department on the ground that they are not, under present conditions, actuarially computable and hence not insurable.

Dr. Henry J. Mineur (Union): How can you get statistics so that you can arrive at some actuarial decisions on some of these matters? Do we have to wait until statistics are available and experience has been obtained? In other words, are we stymied at this point in the extension of the Plan benefits? Just how do you propose to go about extending it?

Dr. Schaaf: When we tried to get the consent of the Department of Banking and Insurance to the offering of riders, their principal objection was that we had no actuarial data upon which to base a premium rate. But we pointed out that in our contract we have a provision for changing the rate at the anniversary date without writing a new contract. That was a feature introduced into the 1956 contract and it materially simplifies our problem.

So it was suggested to the Department of Banking and Insurance that we come up with the best rate we could estimate from available data, to give that a trial for a year and then find out whether the rate was too high or too low. If the rate was too low, we would get an increased rate on the anniversary date. If it was too high, we would diminish the rate to its proper level. This is a purely exploratory and experimental approach. If the Banking Department agrees with it, we will then develop, as we did in the very beginning of the Plan, our own actuarial data upon which a reliable estimate of premium rates can be based. It is a very practical approach and those of us who have given it study think that it will be effective and satisfactory. Thus the answer to your original question is that we do not have to wait until we get cumulative statistics from other agencies.

Dr. Goller: Sir, would you explain in the first place how the Trustees of the Medical-Surgical Plan were chosen? Do they have a term of office? How it is possible for anyone to become a member of the Trustees of the Medical-Surgical Plan?

Dr. Schaaf: We are a corporation with a Board of Trustees. Membership on the Board is brought about by the Board offering nom-

inations to The Medical Society of New Jersey for their consideration and approval. If approved by The Medical Society of New Jersey, that candidate is then elected by the Board of the Medical-Surgical Plan. The appointment is for one year. Every year since the Plan began, which was 1942, this House of Delegates has passed on the nominees of the Board of the Medical-Surgical Plan for re-election or for primary election. Following this meeting the Board is informd that The Medical Society of New Jersey approves the nominations. At our next meeting, which will be May 25, the Board formally elects those Trustees. There is no legal time limit on the number of years that a Trustee can serve, but membership is entirely dependent upon the advice and consent of The Medical Society of New Jersey.

If and when vacancies occur on the Board, we would consider any nomination offered to us from any source. Having considered it and decided that that is the person we are going to nominate, then the same mechanism obtains. It has to go back to The Medical Society of New Jersey and finally the election is held.

The selection of the Trustees and their term of office is entirely dependent upon the will of this body.

Dr. Goller: Is there any way that a man can become a Trustee, other than through recommendation by the present Board of Trustees? What I'm getting at is this: it looks like a self-perpetuating Board. Is there any other way that a man can become a Trustee other than through recommendation from the present Board of Trustees?

Dr. Schaaf: It can be done in reverse, in this way: If The Medical Society of New Jersey is eager to have any particular member on that Board, all they have to do is to indicate the desire to have that member and he would be given first consideration upon the occasion of a vacancy. So that it could originate with your Society. We would then make the recommendation, send it back to your Society for approval and bring it back. It can be done that way. It has been done that way.

Dr. Mineur: Along that same line, are there any corporate members other than the Board of Trustees?

Dr. Schaaf: That is right. There are no members of the corporation other than the Board of Trustees. That is true of the Medical Service Administration, incidentally.

Dr. Alexander H. Fishkoff (Middlesex): With respect to payment direct to participating physicians in contrast to non-payment to those who don't participate, I'm not particularly prejudiced because I am a participating physician, but it seems to me that rather than bludgeoning men into joining the Plan by that procedure it would be far better to continue in the same manner as we did before—payment directly to the physician regardless of whether he is participating or not. What motivated the group to change that?

Dr. Schaaf: Why did the Board of Trustees adopt the present procedure? It was at the urgent and repeated behest of this House of Delegates that some special consideration be shown to the participating physicians in recognition of their participating. Actually we could not adopt it until we offered the 1956 contract; and we could do it then only by convincing the Department of Banking and Insurance that that particular method of payment was in the interest of the subscriber; and the Banking Department was so convinced.

Payment to the subscriber rather than to the non-participating physician is, in no sense, a penalty for non-participation. Direct payment to the physician is a reward for participation. You can argue that it's the other way around, but it is not so intended, it was never so intended and it came about only because of the urgent, almost command, of this body.

What the doctors must realize is that we have a contract with two people. We have a contract with the participating physician who is willing to render the service for the fees to be paid. We have a contract with the subscriber to indicate that we will pay those fees for which we are liable. So by payment directly to the participating physician we discharge our obligation to them—to the participating physician and to the subscriber.

Our relationship with the non-participating physician is no different than his relation to the commercial companies or to other insurance agencies. Most insurance companies pay whatever their liability is to the subscriber and let the subscriber settle his obligation with the doctor. So that we are not in any sense depriving the non-participating physician of his rights. And again I would emphasize that that policy was established by this House of Delegates and not by the Board of Trustees of the Medical-Surgical Plan.

Dr. Carl A. Maxwell (Warren): Then can't we follow your line of reasoning a little further and say that we can have the same type of provision in payment to a physician from the Medical-Surgical Plan as the insurance companies do? Many of these insurance

forms have a little coupon at the bottom which the patient can sign saying that I hereby authorize the insurance company to pay this fee directly to the physician. I think in fairness, as long as you have used that comparison, we should make some provision for following along that same line just as the commercial insurance companies do. I also am a participating physician.

Dr. Schaaf: Assignment of benefits has been a greatly debated subject, but this House of Delegates has disapproved it. And while we have done it occasionally, we do not do it as a rule, and when we do do it we require two signatures on the check: one on the part of the subscriber and also the physician. The only way to protect the Plan is to have the subscriber's signature on the check if it is paid directly to the doctor. Our obligation is to the subscriber.

Dr. John Thompson, Jr. (Essex): In reference to the two radiology riders you were mentioning, has any consideration been given to the possibility of establishing a deductible clause whereby the patient would have to be responsible for the first portion and the Medical-Surgical Plan be responsible for the next portion and have that limited?

Dr. Schaaf: We haven't gotten far enough along to contemplate a deductible feature. It has its disadvantages and actually there is not much reason for doctors operating an insurance company on an indemnity basis, and that is actually what it would be. So the answer is no, we are not contemplating deductibles.

Dr. Charles A. Landshof (Hudson): Could you explain why the costs of the new contract would take two or three years to accumulate while the surplus would appear the first year and only disappear in two or three years? Wouldn't the costs occur concomitant with the premiums that you collect?

Dr. Schaaf: I will ask Mr. Durgom to answer that because he is an expert on the actuarial aspects of this work.

Mr. Durgom: The question to be answered directly has to do with the element of underwriting on the one hand and the element of human behavior on the other. There have been two conflicting forces at work in the last several years of Blue Shield. The Blue Shield Plan in New Jersey has grown more rapidly; in fact it was the fourth most rapidly growing plan among the 73 Blue Shield plans in the country. Through such rapid enrollment you get an abnormal volume of subscription income prior to actual utilization by such new subscribers, other than the immediate repair work that they may want. But you don't have the exposure until three years have passed to complete a cycle among the people who have enrolled for an anticipated or unanticipated need for medical care. The anticipated could be in groups where you know there is no health statement; and it is unanticipated among the individuals.

The other conflicting force at work is the relatively heavy cancellation whereby your better risks drop out and as a result your worst risks stay on. This past year has been the highest period of volume of cancellation not only in New Jersey Blue Shield but throughout the country. It is associated with rising unemployment. Therefore, the amounts which are shown in terms of a reserve at hand in Blue Shield today are really amounts that are in suspension accounts, you might say, until the proper exposure takes place. Perhaps over this three-year cycle there can become a better balance between these two conflicting forces at work whereby hopefully unemployment will not continue to rise, while those who had recently enrolled will be getting into that area of the utilization to hit the normal level.

Dr. Schaaf: Thank you very much, Mr. Durgom. That's a very good explanation, and there is one other thing. We don't pick up our maternity load until nine months after the contract is issued, so that you get a maternity build-up there that has added to the reserve. Once we pick up the full projected load, the maternity benefit demands will be much higher than they are currently. So it's simply that we haven't reached yet the maximum demands.

But another thing that happens, subscribers, particularly new subscribers, don't realize the available benefits immediately. After a while they realize that they are entitled to certain additional benefits and then they begin to use it more. This has been dramatically demonstrated in the sharp rise in out-patient service. It's gone up something like 30 in a thousand in the past year or two. This is because they have become aware of the fact that that service is available in hospital operating rooms. In-patients have not dropped; that's a vital thing. The out-patients have substantially increased; in-patients have increased only slightly.

Dr. James O. Hill (Essex): In the surgical cases where the total fee for the surgical case is paid by the plan and you have one or two assistants, who determines the amount that the assistant gets in this case?

Dr. Schaaf: There is no provision for the payment of surgical assistants in this contract. This is the fourth contract we have offered and none of them have provided fees for surgical assistants. After all, under mod-

ern surgical practice, most surgeons use trained assistants and trained house staff personnel. They do not pay these assistants out of their fees. They have salary arrangements, individual payment for services and so on.

Your problem is that of a general practitioner who refers a case to a surgeon and then participates in the actual conduct of the operation. In those cases the referring practitioner is supposed to send his own bill for that particular service.

We do have an arrangement for apportionment of available surgical benefits. It is an involved arrangement and demands for it are diminishing—they had not been great to begin with—and it is quite likely that before very long the Plan will recommend to the House of Delegates that we be authorized to abandon that procedure.

Dr. Wilson (Bergen): I was interested in what Mr. Durgom said about the cancellations of our insurance during the recession. Is that cancellation greater, for example, in our type of insurance than it is in automobile insurance or fire insurance? And if it *is* greater, is there something faulty in the way we sell our policy to the customer?

Dr. Schaaf: Dr. Wilson, I'm going to ask Mr. Durgom to reply to that.

Mr. Durgom: Very briefly, Dr. Wilson, there is really no comparison between the automobile insurance and fire insurance on property on the one hand and health insurance on the other. Casualty insurance such as automobile is becoming more and more mandatory by law. Laws insist that people have automobile insurance or pay a flat fee into the State, as is the case in New Jersey. In effect in automobile insurance and also in fire insurance, it is not a matter of cancellation or dropping out and not having coverage but really shifting from one casualty company to another. But in the field of voluntary health insurance, the question is whether the person can afford to continue the coverage.

Today the greatest number of employers are paying for the coverage for their employees while they are at work. It is a new concept in the social economics of health insurance as compared to some ten years ago when most of the employees enrolled by payroll deduction whereby premiums were collected from their wages. When people leave their jobs today, if they are laid off, these people are for the first time, exposed to the problem of paying the premiums themselves. You have two reactions as a result of that. The new experience, not having paid premiums before, raises the question of whether they had ever intended to want it except through their jobs as part of the general welfare program of their employer. On the other hand, it may be that they do want it; but seven out of ten do *not* continue after they leave their jobs. So it's just one of those elements of human behavior or else the matter of economic ability to really pay.

Dr. Lester A. Barnett (Monmouth): We are all familiar with the applicant who indicates on his service form that his combined income is less than $7500 when we know that his income is far above that. In a recent visit of one of your representatives at our hospital he stated that if this is the case the physician may notify the Plan and the Plan will investigate the income of this applicant and if it is not truthfully represented the Plan can cancel the contract or take other action.

Now, in a recent case in our county this was done, to the embarrassment of the physician. The applicant was contacted directly and told that they were being investigated as a result of the physician's appeal.

Dr. Schaaf: I don't know what happened in this particular case. Almost anything can happen once in a while in administration. We all make bloopers. However, in general when we have a request from a physician to ascertain for him the actual or probable income of a subscriber, we discreetly call the employer and ask what that actual income is and we then tell the doctor quietly what that income is as we learned it. Of course, that method is not free from possible evasion, but it works very well.

My own personal experience of a good many years of operation with the plan, with professional contact with the plan was that the vast majority of people were honest in their statements. That is particularly true of lower income people. The average workman, if you say to him, "George, how much do you make a week?" says "I get $65 take home pay." You can count on it that it's usually correct. You may ask if it is possible to chisel. Sure, it's possible to chisel, but I'm sure that the amount of chiseling is small.

The way for a physician to handle that particular problem is this: He sends a bill for what he thinks his service should be, if it's $400 or $300, and we get his bill and then we send him a check for whatever we are liable for. We also send a notice to the subscriber that we have paid Doctor So and So so much. The doctor can then send a bill for the balance to that subscriber and if he is pretty sure that the income limit is above the $7500, let the subscriber prove to him that it is less than

that. That's a practical way of doing it.

Dr. Joseph M. Gannon (Union): In this proposed laboratory and x-ray payments outside of hospital, do you contemplate paying that to any physician or just to recognized specialists?

Dr. Schaaf: We haven't decided that, but I think it would have to be a recognized radiologist or a recognized pathological laboratory. All laboratories in New Jersey now are licensed and I think we'd have to make the payment to a physician who was operating a pathological laboratory licensed by the State. There would have to be a definite restriction on that.

Dr. Gannon: I'm an internist and a hematologist. I'm also recognized as a specialist in laboratory work but I'm not doing laboratory work. I'm sure you are well aware of the laws of economics and are aware that by such means you are able to put me out of business, which I feel in the past has been pretty true. You are doing your best to put me out of business; just another step in that direction. A time will come when there will be a fight on this. How far can you push individual doctors? This is just another push in that direction. What right has anybody to set up such a discretionary schedule?

Dr. Schaaf: What we have tried to do is two things: One, to meet the requirements or urgent requests for inclusion of a certain amount of x-ray and a certain amount of laboratory service in our contract. We tried also to carry out the directives or requests of the House of Delegates of The Medical Society of New Jersey. Now, indiscriminately to offer to pay for blood counts and chest x-rays and so on would inevitably break the Plan; so we have to put some kind of a stop-loss on it.

What we are trying to do will be to meet the requirements of the radiologists and pathologists who up to now have not been considered in any of these Blue Shield insurance plans. If we adopt this method we may ultimately adopt payment for home and office care which makes the cost of the program almost prohibitive. Then the internist would get his ten dollars for his office call or whatever it is he is getting and that would have to include whatever clinical pathology he did. You just can't differentiate it.

We are trying to do something for the clinical pathologist and the radiologist and we are trying to do it only because this House of Delegates has urgently requested us to attempt an exploration of the field.

Dr. Gannon: You are not aware of the elements of economics. Gresham's Law has not been repealed by the Medical-Surgical Plan. Cheap money will always put good money out of business in any society. There is no way that I can compete when a patient comes in to have some blood work done if he can get it done, as he considers it, "free" across the street. He can't see the difference and I don't think it is right. Some day somewhere somebody's going to see that point. But so far no one has seen it.

Dr. Schaaf: On the other hand, the pathologist has an equal right to say, "Doctor, you shouldn't be practicing pathology;" or "You shouldn't be doing blood work."

Dr. Gannon: That's the most ridiculous statement I ever heard. What pathologist would ever say that? He has no right to say such a thing. He has no right. And if he did, I'd tell him to his face. Some day this has got to be thrashed out. Your rules are based on the greatest good for the greatest number. It's a pernicious doctrine. It doesn't protect the rights of individual doctors and I want them protected. That's Americanism. I don't want any socialism that's over in Europe that's torturing that continent and this is what you are coming to with this plan. You always are pushing the individual out and say it's good for the group. Our Constitution wasn't good for the group. Our Constitution in America protects me as an individual against the group and that's what's wrong with this whole setup and I'm pretty mad about it.

Dr. Schaaf: Well, I realize that you are angry about it and I'm sorry, but it's not the result of the machinations of the Medical-Surgical Plan of New Jersey; it is the pattern of medical practice and our operations are directed within that pattern and they are, shall I say, authorized by this House of Delegates.

Dr. Robert Brill (Passaic): As a pathologist, perhaps I can give the other side of the picture. I know Dr. Gannon. He was my predecessor at a large station hospital in England. I came in and he moved somewhere else.

Dr. Gannon is fortunate because as an internist he is well qualified to do laboratory work and I think there should be no emotional warmth about this.

Our commitment is not our own economic good. Our commitment is what is best for the patient and I contend that although there may be some internists who are competent to do good laboratory work and who hire registered technologists to do this work, there are other general practitioners and internists who are *not* qualified to do good laboratory work

and who do not hire registered technologists. Instead they employ girls with fly-by-night training in a school of medical technology which is not approved by the American Medical Association. They pay these girls a moderate sum. These girls produce a great deal of revenue for these doctors.

I could tell you tales where a good internist asked me why his urea nitrogen determinations were higher than comparable ones on his patient in the hospital. He was using an anti-coagulant with ammonium and potassium oxalate and the end point for reading this is the production of ammonia. For that reason he was getting erroneous results. And comparably he was using the wrong anti-coagulant for his hematocrit and shrinking his red cells by not using an isotonic anti-coagulant. He did not change the red cell size.

Although there may be many inconsistencies as far as individual physicians are concerned, I think that the deliberations of this group and of the Trustees of the Medical-Surgical Plan should be devoted to the overall good of the people in the State of New Jersey, the people whom we are dedicated to serve.

I would like to add this, Dr. Schaaf: I know that the Board of Trustees of The Medical Society of New Jersey is working along with the radiologists, with the pathologists and with the hospital administrators in an attempt to transfer from Blue Cross to Blue Shield payment for those radiologic and pathologic services which the AMA and many states have gone on record as stating are the practice of medicine. This is a slow and tedious job, but we hope eventually to get there. Certainly speaking for the pathologists, we are not out to take money from the hospitals. We would like the hospitals to continue to have adequate remuneration as they have in the past. We only want to establish what is the practice of medicine in the hands of physicians. In many states, laboratory and x-ray services are paid for from Blue Shield; that is, medical-surgical funds, and I would like to offer the services of Dr. Erdman and Dr. Gewanter who have been working with the Board of Trustees of The Medical Society to guide you if you would like actuarial assistance.

Dr. Schaaf: Thank you, Dr. Brill. Now, Dr. Gannon, I might offer a solution to your problem. If we adopted this and limited it to licensed laboratories, all you'd have to do is license your own laboratory and it could be done and you would then qualify for such payment.

Dr. Jacob M. Schildkraut (Mercer): Speaking of licensed laboratories, I want to call to your attention that there are licensed laboratories in this State that are not run by physicians. What will you do in a case like that?

Dr. Schaaf: Our payments are made only to doctors of medicine or persons licensed to practice medicine. That includes doctors of osteopathy. We would not pay the non-medical laboratories.

Dr. Carl G. Kapp (Union): For a long time the Plan has had the principle that they could not distinguish fees from men who had specialized in various branches of medicine. Now, are you abandoning that principle to say that you can establish a fee for a pathologist or an x-ray man? Because if you do, you are opening the door. Many other specialties will say if that's so for them, why shouldn't it be for us? Your strength with the Plan has been the principle that your fee was not the largest, but was an average surgical fee.

Dr. Schaaf: It's not quite the same thing. You see, we have physicians and we have surgeons and we have obstetricians and we have radiologists, we have pathologists, and in that way we do distinguish between types of service. But we do not distinguish between grades of service within respective types. For instance, it would be inequitable to pay a consulting fee to a physician who was certified by the Board of Internal Medicine and, for the same service, refuse to pay it to a physician who was not certified by the Board of Internal Medicine. I know of a number of physicians who are not certified by the Board of Internal Medicine whom I would choose as personal physicians to myself on the ground of their competence.

The Plan has no means of determining the competence of physicians. We just can't differentiate between grades of service in the same category; so it is not correct to say that we are abandoning the differential in grades of service. But we are developing two other types of service—we have four presently and we get two more. So that it's not quite comparable.

Dr. Fishkoff: In the matter of services for accidental injuries that have occurred within 48 hours, what about after care? Is that considered as part of the original payment for injuries?

Dr. Schaaf: I'm going to ask Dr. Alfano on that because he is an expert on the adjudication of fees.

Dr. Alfano: In the case of accidental injury, when the initial services are rendered within 48 hours our Plan will pay for the

routine follow-up care up to a maximum of $50 for that original accident. It continues until the patient is discharged by the physician.

Dr. Fishkoff: Apparently that hasn't been the case in many instances. I think probably your office personnel haven't been properly instructed.

Dr. Taylor (Gloucester): Doctor, why wouldn't your plan be better off by putting a limit on the amount of x-ray service that is allowed like, say, the Pennsylvania plan does? Its subscriber pays over and above a certain amount.

Dr. Schaaf: That's exactly what the proposal is: that they would have diagnostic x-ray service out of hospital up to the amount of $100 in a given contract year, so that the limit is they pay over $100. The question that Dr. Thompson raised over here was whether we would have a deductible of $25 or $50 before we began to pay. That's quite the reverse, you see.

Dr. Taylor: But you are talking about outpatient. I mean in-patient contracts. For example, the Pennsylvania plan allows x-rays up to $35 if a patient is in the hospital. Above that they are billed by the hospital or by the radiologist of the hospital for the difference I wondered why it wouldn't be more feasible and better to the plan, and without setting the rates up, to have such a plan as that.

Dr. Schaaf: Well, actually that involves the Hospital Plan more than the Medical-Surgical Plan. I thought I had covered it earlier, so far as the Medical-Surgical Plan is concerned, by stating that we didn't want to participate in a program where the hospitals are competing with private practitioners on the outside. I'll be glad to ask Mr. Durgom to take up your question.

Mr. Durgom: In New Jersey, the Blue Cross Plan, as conceived 25 years ago, was always a so-called "between service" coverage. There were no indemnity limitations. Curiously enough, 20 years ago the Philadelphia Blue Cross Plan was organized and, as you say, doctor, has had this limitation of $35 in the x-rays as laid down by the Philadelphia County Medical Society. But within the past several weeks there have been hearings in Philadelphia on the Blue Cross rate increase. Testimony was taken from the medical profession, from labor as consumers and from hospitals as dispensers of service. There is now coming out an overhauling of the Philadelphia Plan, and they are going to go to the all-inclusive comprehensive plan or to having some form of deductibles at the bottom of the whole bill rather than picking out certain detailed itemized services. The present day market does not want these limitations measured by dollars. That is the function of commercial insurance; it is not the function of the voluntary, non-profit plan and that is why the consuming public would rather pay a higher rate in terms of enrollment cost and get full coverage than be exposed to these indemnity limitations.

Dr. W. Laurence Bonnet (Mercer): You indicated, sir, that the moneys belong to the subscriber. Might it not be thought of that the moneys belong to the suppliers of the services and that the subscriber only owns the eligible services when the need arises?

Dr. Schaaf: Oh, no. The subscribers own the funds and out of those funds we pay his liabilities. It states specifically in the enabling act that the Plan shall be operated for the benefit of the subscribers. That's the basic tenet; it's the thing that we must bear always in mind. The Banking Department invariably reminds us of that. Anything we want to do, they'd ask one question first: Is this in the interest of the subscriber? If you can't demonstrate that it is in that interest, you can't do what you want to do. The answer is that the subscribers own the money. They simply made a pool out of which we, their agents, pay their liabilities.

Do I see any more hands? If not, thank you all for coming. Its been very stimulating to all of us. We hope we have learned something from you.

Psychiatry for GP Booklet Available

Any physician in New Jersey will receive, on request, a copy of *Psychiatry for General Practitioners*, report of lecture series at the Carrier Clinic in Belle Mead, N. J. To get your copy, write to Medical Director, Carrier Clinic, Belle Mead, N. J.

Announcements • • •

Cardiology for the GP

Mark down Saturday, January 10, 1959. On that date, the New Jersey Academy of General Practice will hold its 7th Scientific Session. This one is at the Traymore in Atlantic City (a wonderful place on a winter week-end!) and the practitioner who attends the lectures gets 5 hours AAGP credit (Category I). There is a special women's program for the lady you will bring. The scientific assembly consists of 5 phases of cardiology for the GP:

Management of Hypertension by Garfield G. Duncan, M.D.
Cardiac Emergencies by Charles Enselberg, M.D.
Cardiac Surgery by Charles Bailey, M.D.
Atherosclerosis by Norman Jolliffe, M.D.
Rehabilitation of the Patient who has had Coronary Disease by William A. Jeffers, M.D.

There is a dinner-dance scheduled for Saturday night, too. Make arrangements directly with the Traymore.

Hypnosis Group Organized

Announcement is made of the formation of a New Jersey chapter of the National Society for Clinical and Experimental Hypnosis. The president is Milton Jabush, M.D., of Lakewood, N. J. For application blank and further information, write to Dr. Jabush at 121 Madison Avenue in Lakewood, N. J. Membership includes psychologists, dentists, and all professional personnel interested in ethical use of hypnotism.

Ob-Gyn Boards

The next scheduled examinations (oral and clinical) in gynecology and obstetrics will be held at the Edgewater Beach Hotel, Chicago, from May 8 through 19, 1959. Candidates who participated in Part I examinations will be notified of their eligibility for the Part II examinations.

Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

Mailed Blood Specimens May Freeze

The New Jersey State Department of Health, Division of Laboratories, again reminds physicians that blood specimens mailed during the cold, winter months are subject to freezing en route. Freezing renders such specimens unsuitable for examination. The Department strongly recommends that specimens be mailed early in each week to avoid delay of delivery over week-ends, during which time they may be subject to such spoilage.

Blood Specimen Tubes

As soon as the present supplies of "vacutainer" tubes for the collection of blood specimens are depleted, this type of tube will no longer be supplied to the physicians of this State. This change has been necessitated by budgetary restrictions plus rapidly increasing cost of this item. New Jersey is the only state where the Health Department is supplying vacuum type blood collecting tubes without cost.

Plain corked glass or corked plastic tubes will be furnished in place of the vacuum tubes when the present supply of the latter has been exhausted.

Blood should be obtained with a sterile, dry needle and syringe (about 7 c.c.). With needle removed from syringe, gently expel specimen into tube and cork tightly for mailing.

Physicians desiring to continue use of vacuum tubes are advised that these are obtainable from regular medical supply houses.

Marginalia of Medicine • • •

This section is for comments, queries, answers and footnotes. Each item is preceded by a bold-face numeral. When writing, please identify the item by that numeral. Address your questions—and answers—and comments to "Marginalia" care of the Editor, The Medical Society of New Jersey, P.O. Box 904, Trenton 5, N. J.

1

In the September 1958 JOURNAL we asked if anyone had a solution to the "Psychosomatic Dilemma"—that is, the problem of how to give psychotherapy to the emotional component of an illness without depriving the patient of medical or surgical therapy, and without confusing the patient by offering him two therapists. Dr. Martin G. Vorhaus of Englewood answers:

The case for the psychosomatic dilemma is well stated but there is a solution. The problem is a current one, another example of man's need to adapt to changing environments. Here, the adaptation is to the complex personal interrelationships among patient, psychotherapist and internist but please take note that the patient comes first.

His diagnosis work-up must be complete prior to referral. Thereafter the management is a dual responsibility. The obligation is professional; it necessitates a satisfactory rapport between internist and psychotherapist. All differences between them must be resolved *sub rosa*. The patient cannot become a shuttlecock, flying back and forth between the bats of two opponents.

This is not an easy solution. It requires time and patience. It is predicated upon the willingness of the internist to understand the transference problems of the psychotherapist; it allows the internist to provide the continuing care which his patient expects from him. This is no theoretical solution; it is being used constantly. It can work and it does work.

Note: Also see article on page 662 of this issue.

2

A south Jersey member wants to know if there is, in organized medicine, any difference between a component and a constituent society? Also: has the AMA composition in this regard changed at all since Arizona and New Mexico became states?

In general, the state societies are "constituents" of the AMA while the county societies are "components" of the state society. The AMA constituency has had three changes since 1912. In 1921 Alaska became a constituent. In 1946 the Philippine Islands Society became detached from the AMA with the new independence of that commonwealth. And last June, the Virgin Islands Medical Society became an AMA constituent.

3

One of our members wants to know if there is any fairly simple formula for deciding when a peptic ulcer should be subjected to surgery and when medical treatment should be tried.

Will any internist, gastro-enterologist or surgeon offer an answer?

4

A doctor in a rural area says he has no access to a medical library and he wants to know how he can get a package of current material on a medical problem.

Try the AMA Package Library. This 40-year old service is still going strong. You write to Library, AMA, 535 North Dearborn Street, Chicago 10, Illinois. Name the subject in which you are interested—making the focus as sharp as possible. They'll send you a dozen or so reprints. It's a loan of course, and you have to return the stuff in a week or two. If you have paid up your AMA dues this service is free. Otherwise, it will cost you 50 cents a package.

5

Victor Huberman says he has heard, for years, that there are more beds devoted to psychiatric cases than to all other illnesses put together. He wants to know if this is true. Also, how many hospitals are there in the country anyway? "Please use round figures" he says, "and leave out the fractions."

It's almost true. In round numbers the score is this: there are 1½ million hospital beds in the country. Of these, 675,000 are devoted to mental cases and, believe it or not, 675,000 are nonpsychiatric beds in general hospitals. What about the remaining 150,000 beds? Half of these are in tuberculosis hospitals, and the other 75,000 beds are in other special institutions, like maternity hospitals, eye-and-ear infirmaries, orthopedic hospitals and so on. There are some 6800 or 6900 hospitals in the U.S.A. The number can't be exact because some institutions are hard to classify. While psychiatric hospitals contain 45 per cent of the beds they account for only 2 per cent of the admissions. More than 22 million people were admitted to hospitals last year—so keep up your Blue Cross!

6

An intern in a Newark hospital asks if any states are losing doctors.

Yes. The big loser is New York. According to the 20th edition of the AMA Directory, there are 360 fewer physicians in New York than there were five years ago. Other states with fewer M.D.s are Missouri and Pennsylvania. The big gainer is, naturally, California, which has increased its physician roster by over a thousand in the past few years. Florida is also increasing. So are most of the western states. Here in New Jersey the doctor-population is increasing in about the same ratio as the population. In 1953, for instance, our Society had 5053 members. Now the roll-call is 6218.

7

A local obstetrician says he ought to know this but doesn't. What's the difference between fertility and fecundity?

In lay language, so to speak, fecundity implies an ability to reproduce offspring in vast numbers whereas fertility merely measures the number of such offspring. Statisticians use the word fertility to reflect the number of babies born to a couple or class, whereas fecundity reports on the *capacity* of the women. A healthy married woman in her 20s has fecundity, but if she is not pregnant, she does not show fertility. Or does some reader want to challenge this differentiation?

8

In this air-age, doctors are expected to know medical contra-indications for air travel. A new practitioner wants to know where he can find a list.

In the March 15, 1958 issue of the New York State Journal of Medicine (58:853) Dr. George Kidera has an excellent article on this. He lists these major contra-indications for air travel. If your patient is not on this list, he can probably travel safely:

Infant under 7 days of age; lack of bowel or bladder control at any age; large unsupported hernia; open, draining abdominal wounds; threatened perforation of ulcer; fracture of jaw held in place by wiring; contagious diseases; anemias with hemoglobin under 60 per cent; sickle cell disease; active tuberculosis; patient with pneumothorax; patient in status asthmaticus; decompensated heart disease; anginal pain precipitated by slight exertion; and bulbar poliomyelitis.

Anybody disagree?

9

One reader says his medical-student son referred to "club-hand." The doctor says he has heard a lot about "club foot" but has never heard of a "club hand." What is it and what can be done for it?

Is there an orthopedic surgeon in the house? Answer?

10

A pharmacist who occasionally sees our JOURNAL wants to know the origin of the word "syphilis."

The traditional story is that Girolamo Fracastoro wrote a poem in 1530 with the title "Syphilis sive Morbus Gallicus" (Syphilis or the French disease) which represents that a swine-herder by the name of Syphilos was the first human being to have the disease. We don't believe it. That is, we don't believe that Fracastoro made up the name Syphilos by pulling lots or using a Ouija board. It seems more likely that the disease had been named before 1530 and that Fracastoro gave his victim the name for the disease. It seems to our possibly naive mind that the word must come from the Greek, *sy*, together, and *philos*, to love. Or, does some historian or lexicographer want to argue with us about this?

County Societies Reports • • •

Bergen

On October 14, 1958, the members of the Bergen County Medical Society saw the AMA film *Highlights of* 1958. The Society then elected to membership Drs. P. J. Enright, F. J. Ferraro, James Fox, O. F. Knowles, T. C. McCormack, J. J. Territo, W. C. Van Ost, A. W. Wyker, W. S. Hitrec, Louis Landman and M. R. Mateyka. Dr. Frank Dain was made a courtesy member. Elected to Associate Membership were Drs. W. M. Sweeney, M. G. Salz, Fernardo Garip, C. C. Cimillo, M. G. Blechman and Elizabeth M. Bogardus.

Dr. Levitas reviewed the poll which indicated that, by a 2 to 1 majority, members wanted to be included in OASI. A motion was passed, directing Bergen County's delegates to bring this to the attention of the House of Delegates of The Medical Society of New Jersey at the April 1959 Annual Meeting. A motion was also passed asking other component societies in New Jersey to poll their members on the matter of inclusion in social security.

Mr. Dudley E. Jacobus then addressed the membership on the problem of stock market operations, mutual funds and related topics. Mr. Jacobus is from the New York Stock Exchange firm of Paine, Webber, Jackson and Curtis.

The Society voted to approve the 1959 budget as printed in the October *Bulletin*. There was then discussion of the problem of compulsory attendance at hospital educational meetings, and this was referred to a newly created Committee on Hospitals for study and report.

The November 11th meeting was opened with Dr. Donald B. Hull, First Vice-President, presiding. Minutes of the regular meeting of October 14 and those of the executive committee meeting of October 21 were accepted as published in the November *Bulletin*.

The Chair requested the following new Regular members to come forward and receive their member certificates and wallet identification cards: Patrick F. Enright, Frank J. Ferraro, James Fox, Otho F. Knowles, Thomas C. McCormack, Joseph J. Territo (absent), William C. Van Ost, Arthur W. Wyker, William S. Hitrec, Louis Landman, and Milan R. Mateyka.

The Chair asked the following new Associate members to rise: Martin G. Blechman, Elizabeth M. Bogardus (absent), Carmelo Cimillo, Fernando Garip, Michael G. Salz (absent), and William M. Sweeney.

The Secretary read the following names, which had been approved by the Executive Committee for election:

To Regular from Associate—Jesse D. Greenberg, Herbert E. Keller, Joachim Oppenheimer, Lelio N. Passaglia; To Regular by transfer—Richard D. Dugan (from Med. Soc. Co. of Rockland); To Regular—Thomas F. Lynch; To Courtesy—Edgar G. Braunstein, Eugene Gottlieb, Ottavio J. Pellitteri; To Associate—Gerald R. Frolow, Richard P. Gilligan, Anthony V. Porcelli, Edmondo Sugar.

On motion the Secretary was instructed to cast one ballot for the election of these applicants.

Report of the Building Committee: Dr. Winton H. Johnson, Chairman, reported that the Society's application for a variance from the zoning ordinance had been denied by the Board of Adjustment of Teaneck. The Davis property was, therefore, not available to the Society. On motion, a resolution of deep appreciation to Dr. Johnson and his committee was recorded for their untiring efforts to find a permanent home for the Society.

Report on Social Security Resolution adopted at last Regular Meeting: The Executive Secretary reported that in accordance with the resolution adopted at the October Regular Meeting, letters had been sent to each County Society in New Jersey, requesting that they conduct a poll to ascertain their reaction to compulsory inclusion in O.A.S.I. and that these results be forwarded to The Medical Society of New Jersey prior to its next Annual Meeting.

The Secretary read an excerpt from the Executive Committee Minutes of October 21 in which it was voted to recommend a contribution of $500 to the Albert Barker Kump Memorial Fund. On motion, this recommendation was approved. A resolution was read by the Secretary, on the death of Dr. D. V. Leddy. This was passed. A copy will be sent to the bereaved family.

Resolution on nomination of Dr. W. L. Vroom as A.M.A. "GP of the Year": The following resolution was read by Dr. Donald B. Hull and on vote by the Society was unanimously passed:

Whereas, William Loveridge Vroom, M.D., has been an active member of the Bergen County Medical Society since 1888, its President in 1905 and is a member in good standing, and

Whereas, he has been for more than a half a century a civic leader in his community of Ridgewood, New Jersey, having served it as a member of the Board of Trustees of the Village, a member of the Board of Health, the originator of the village water and sewage systems, Coroner, one of the founders and directors of one of its leading banks, founder of its first hospital, and at the age of eighty-two was active in the organization, fund raising and building of its new two million dollar community hospital, and

Whereas, Dr. Vroom was the first physician in this County to use insulin, diphtheria anti-toxin in clinical practice, instituted the first mosquito control measures and has practiced medicine as a country doctor, including the delivery of well over 2000 New Jersey residents in his seventy years of active practice, and

Whereas, Dr. Vroom's life exemplifies the highest qualities of physician, friend, counsellor, civic leader, student and teacher;

Now Therefore Be It Resolved: that the members of the Bergen County Medical Society submit his name in nomination to the American Medical Association for its 1958 "General Practitioner of the Year" award, and

Be It Further Resolved: that a copy of this resolution, together with the story of his life, be forwarded to The Medical Society of New Jersey with the request that The Medical Society of New Jersey support this nomination.

Dr. Hull called upon Dr. Tor Richter, Chairman of the Scientific Program Committee, to present the program for the evening. Dr. Richter presented a sound moving picture on cardiovascular surgery prepared by the Presbyterian Hospital, New York. He made a brief commentary on each of the films.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The October meeting of the *Cumberland County Medical Society* was held October 14, at Richards Farm, Rainbow Lake, N. J., with M. David Baxter, M.D., of Vineland, presiding. There were 43 members present.

The following men, who were approved by the Executive Board as Associate Members, were presented: Joseph A. Bonaccorsi, Anthony F. Napoli, Walter Pavlin and Ahmet Samedov of Vineland; Charles E. Eby, Gerald Eichner and Alfred C. Elmer of Bridgeton.

Gabriel Tatarian, M.D., transferred from the Philadelphia County Medical Society and was unanimously elected to Active membership.

The Annual Diabetes Detection Drive, under the chairmanship of Milton Fineman, M.D. of Vineland, will be supported by the Society.

Samuel B. Pole, III, M.D., of Bridgeton, reported on the Annual Glaucoma Detection Week Clinic. Of the 197 people examined, 119 had sub-normal vision and 33 showed pathologic changes in the eye grounds.

A silver tray was presented to Carl Nash Ware, M.D., of Shiloh, for his outstanding work in the medical society at state and county levels. The engraving on the plate read:

> "In recognition of services rendered to organized medicine and to his colleagues in the county of Cumberland and State of New Jersey, U.S.A."

Dr. Ware gratefully accepted the gift.

The guest speaker, Raymond W. Hillyard, M.D., was an Associate in neurosurgery at all of the Wilmington, Delaware, hospitals. The subject of his address was: "Management of Head Injuries." Dr. Hillyard gave the classification of head injuries, stressing the importance of watching closely the reaction of the patient and to arrive at the correct diagnosis and then to see that the proper management is carried out. The discussion that followed was indicative that Dr. Hillyard had stimulated the thinking of his audience.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

The regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on November 4. Dr. John J. Bedrick presided.

Guest speaker for the evening was Dr. Leon Ginsberg, Director of Surgery, Beth Israel Hospital, NYC and Clinical Professor of Surgery, NYU Medical School. Dr. Ginsberg's presentation was entitled "Surgical Treatment of Large Bowel Tumors." Many doctors participated in a very interesting discussion from the floor.

The Society passed the following resolution:

Whereas, it is a function of The Medical Society of New Jersey to support and protect its constituent members;

Whereas a physician-member of The Medical Society of New Jersey has been sued improperly and harmed unnecessarily;

Whereas this physician has requested assistance from The Medical Society of New Jersey in a countersuit to achieve vindication;

Whereas The Medical Society of New Jersey Defense and Insurance Committee has urged society action along these lines, both in general and specifically in this instance, so that some liability cases may be prevented.

Be it resolved that the Hudson County Medical Society strongly recommend to the Board of Trustees of The Medical Society of New Jersey that the New Jersey Medical Society become a party to a countersuit against the plaintiff and her lawyers under the terms of S-234.

Be it further resolved that a copy of this resolution be forwarded to the special committee that was appointed by the President of The Medical Society of New Jersey to study this matter.

The Secretary was directed to send a copy of this resolution to all component medical societies in this state.

Elected to Active membership were: Drs. Bernard Abers (reinstated), John J. Calabro, Mario Gagliardi, Iwan Nowakinskyj, Michael Pacicco (reinstated), Martin Silbersweig, Morris Soled, Tamara Tanner, and Michael D. Yablonski, all of Jersey City; Frank Lofaro and Murray J. Pozner of North Bergen; Charles Rosenzweig and Carl J. Silodor of Bayonne; Edward W. Luczynski, Jr. of Arlington; Franc Puc of Hoboken; Leonard J. Thalheimer of Coytesville.

CLEMENT M. JONES, M.D.

Reporter

Mercer

The final 1957-58 meeting of the *Mercer County Component Medical Society* was held at the Trenton Country Club in conjunction with an outdoor picnic. Fun, food, and door prizes were arranged by our Entertainment Committee, under the chairmanship of Dr. Joseph R. Burns, assisted by Drs. William H. Coleman, Henry L. Drezner, and Peter J. Norton. During a short business session, Drs. Jonathan A. Hammond, Thomas J. Kelley, Jr., and Benjamin M. Wright, were elected to Active membership; and Drs. Siu-Won Chan, Guillermo J. Munoz, and Joseph L. Mooney, to Associate membership.

Our first two meetings of the year were held in the auditorium of the Executive Building of The Medical Society of New Jersey, with President Samuel J. Lloyd presiding.

The first meeting, held October 8, was devoted to the transaction of routine business and the election of Drs. Seymour Cohen, Edward R. Hawkins (on transfer from New York County Medical Society), Werner J. Hollendonner, Vincent B. Pica, John C. Stillwell, and Edward J. Surowiec to Active membership. Drs. Bertram H. Frohman and Marion Makohin were elected to Associate membership.

The film, "The Doctor Defendant," was shown at our November 12th meeting, followed by a lively and interesting commentary and question and answer period made possible through the graciousness of the Honorable Richard J. Hughes and the efforts of our Program Committee, under the chairmanship of Dr. Kurt Zeltmacher. During the business portion of the meeting, (a) Drs. William J. Dougherty and Eugene Hrabarchuk were elected to Associate membership; (b) a resolution concerning a proposed retirement contribution plan for New Jersey physicians, presented at the Annual Meeting of The Medical Society of New Jersey in May, 1958, was re-approved, to be forwarded to the Trustees of The Medical Society of New Jersey and to each county society for their action, urging the Medical-Surgical Plan to participate actively in the retirement program. In addition, the resolution provides that this subject be placed upon the agenda at the open meeting of the Medical-Surgical Plan of New Jersey during the 1959 session of the House of Delegates of The Medical Society of New Jersey; (c) the name of Dr. R. John Cottone was approved as our candidate for the office of Second Vice-President of The Medical Society of New Jersey in 1959; (d) a proposal was offered to amend our Constitution to effect an increase in meeting attendance by Associate members, and to institute a new policy that all Associate members engaged in the private practice of medicine make themselves available for service on our Emergency Medical Service Panel. The proposed amendment was referred to the proper committee for consideration.

Refreshments were served by members of the Woman's Auxiliary following each meeting.

LAWRENCE I. BONIN, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. George J. Kohut, president, at the Roosevelt Hospital, Metuchen, October 15, 1958 at 9:00 p.m.

Dr. Benjamin F. Slobodien, Chairman of the Judicial Medical Ethics Committee presented applications for membership as follows:

Regular—Severin J. Ambrosio, Parlin; Harry K. Fidler, Leon Martin and Harold P. Curran, of New Brunswick; Associate—Mauro De Girolamo, Parlin; Eugene De Angelis, Highland Park; and John Sergeant, Sayreville.

These were accepted by an unanimous vote.

Dr. Charles H. Calvin, chairman of the Constitution and By-Laws Committee, reported that it may be necessary, in the future, to obtain legal review of the new by-laws in order to make them proper.

Dr. Calvin requested that the membership of this Society form a fee schedule as requested by the officials of the County Institutions. This fee schedule would be used by the Old Age Public Assistance for payment to physicians in their treatment of welfare cases. A motion was passed to refer this to the Board of Trustees for study and assignment of fees. The Board would then report the recommendations to the membership at the next meeting.

Dr. Edward F. Balsbaugh introduced the guest speaker, Dr. Fenton Russel, a toxicologist from Du Pont de Nemours Company, who gave an eloquent, dramatic and enjoyable paper entitled "The Ether Controversy—A History of Ether as the Anesthetic Agent." This was an appropriate topic as the meeting was held on the eve of the anniversary of the finding of surgical anesthesia.

Dr. Reuben Levinson, treasurer, gave a financial report. The Society voted to keep the dues for regular members the same for 1959 as it had been the past two years. The special $5.00 credit allowance to each member would be allowed.

Dr. Harold B. Fein brought to the attention of the members that various organizations had clinics for the administration of Salk vaccine either free or for a very small fee, and wanted to know the Medical Society's position in this matter. Dr. George J. Kohut, president, then read a few letters directed to the County Medical Society from organizations requesting the Salk vaccine clinics. On motion, this matter was referred to the Public Relations Committee. A motion was then passed that no member of the Society participate in or give approval to these new or intended Salk vaccine clinics until the membership is given a report of the findings of the Public Relations Committee.

DONALD T. AKEY, M.D.

Reporter

Passaic

The annual installation dinner meeting of the *Passaic County Medical Society* was held in lieu of the regular monthly meeting, for the purpose of introducing Dr. Theodore K. Graham, as the President, and the other officers of the Society. The meeting was held at the Alexander Hamilton Hotel on October 1.

Dr. Julian Cohen, Chairman of the Dinner Committee, opened the meeting by introducing Rabbi Martin Freedman who gave the invocation.

After dinner, the only business transacted was the election of new members. The Secretary read the list of candidates. The following were elected to Associate membership: Dr. Theodore Ceraolo of Wayne and Dr. Pasquale Racaniello of Paterson. Elected to Courtesy membership was Dr. Jerome M. Torsney of Clifton.

Dr. Sandor A. Levinsohn served as master of ceremonies, and conducted the program in his usual jovial manner.

The immediate past president, Dr. Samuel C. Yachnin, was presented with a plaque in appreciation of his services during the past year. He gave a resume of the many demands made upon the president of a county society, and spoke of the short duration of idleness of a past president, insofar as society duties are concerned, before other duties await him. He also suggested that the members become more interested in the functions of the committees of the society.

Dr. Theodore K. Graham, the president, was then introduced by Dr. Levinsohn. Dr. Graham stressed the need for physicians to take part in community service through the Medical Society. He said that in this era more is expected of a physician than administering to the physical needs of his patients, and asked for greater participation in the affairs of the Society, for the welfare of its members as well as the public.

The other officers installed were: Drs. Julian Cohen, First Vice-President, F. Albert Graeter, Second Vice-President, Joseph E. Mott, Secretary, Frank B. Vanderbeek, Treasurer, David B. Levine, Reporter, John A. Ianacone, Editor.

Guests at the dinner included Dr. Kenneth E. Gardner, President of The Medical Society of New Jersey, and its Executive Officer, Richard I. Nevin, both of whom addressed the group briefly. Also among the distinguished guests who were asked to take a bow were The Honorable Paul G. De Muro, Mayor of Passaic, and The Honorable Stanley Zwier, Mayor of Clifton: Distinguished guests were also Drs. George Heller, President and Donald B. Hull, First Vice-President of the Bergen County Medical Society; Mr. John F. Crane, Director of the Paterson General Hospital, Mr. Joseph A. Mattson, Administrator of the Passaic General Hospital, Mr. Harvey Schoenfeld, Director of Barnert Memorial Hospital, Mr. David Wachs, Superintendent of Beth Israel Hospital, Miss Ruth Taylor, Administrator of Chilton Memorial Hospital, Mr. Edwin E. Poage, Assistant Administrator of St. Mary's Hospital. It was also a pleasure to have as guests the Emeritus members of the Society who could attend: Drs. Louis Lipton, Charles R. Mitchell, Charles J. Murn, Andrew B. Vanderbeek, Ralph J. Vreeland and Walter M. Winters.

In introducing the principal speaker of the evening, Dr. Levinsohn said that Dr. Louis J. Bohl was responsible for securing the outstanding Louis A. M. Krause, M.D., Professor of Clinical Medicine, University of Maryland, College of Medicine Dr. Krause's topic was "Biblical and Clinical References to Disease," and Dr. Krause's presentation was so interesting that it seemed the audience was willing to listen to him endlessly.

DAVID B. LEVINE, M.D.

Reporter

Salem

The *Salem County Medical Society* was fortunate to have as its speaker for the regular monthly meeting on October 17 at the DuPont-Penns Grove Country Club, Dr. John R. Rushton, III, consulting psychiatrist to Ancora State Hospital and Elmer Community Hospital. Dr. Rushton spoke on the Medical Approach to Senility.

During the business portion of the meeting, presided over by Dr. Charles Gilpatrick, a member from the Philadelphia Medical Society, Dr. Marvin Balistock, of Salem, was accepted by transfer to the local group.

Dr. Isadore Lipkin, president of the Salem County Heart Association announced two meetings to be held at Salem County Memorial Hospital on the preparation of low sodium diets.

A request from the Vocational School of Salem County for a representative from the Medical Society to their advisory committee was received and Dr. August Jonas of Salem was appointed to that committee.

A nominating committee composed of Dr. C. B. Norton, Dr. Harry Fullerton, and Dr. Isadore Lipkin was chosen to prepare a panel of candidates for the March meeting.

Dr. Garrett Hume introduced a guest, Dr. James Stout, Woodstown, who recently became associated with the Medical Department at Chambers Works.

G. F. REICHWEIN, M.D.

Reporter

New Jersey Orthopaedic Society

The *New Jersey Orthopaedic Society* held its 1958 Annual Meeting in the state of Delaware—at the E. I. du Pont Institute in Wilmington. The meeting was held on October 11 and the orthopedists were guests of Dr. A. R. Shands, Jr., medical director of the Institute. Dr. Roy Ciccone of Passaic, the incoming president, was installed at this session.

Papers were presented on : (1) phagocytosis, (2) surgery for vertical talus in flat foot, (3) fibrosarcoma of bone, (4) congenital indifference to pain, (5) advances in biochemistry, (6) femoral fractures as a complication of electronic therapy, (7) extra-articular arthrodesis, (8) prognosis in Legg-Perthes Disease, (9) hip involvement in rheumatoid arthritis, and (10) torsion of the femur. Speakers were (1) Dr. A. T. Wilson, (2) Dr. S. W. Casscells, (3) Dr. G. D. MacEwen, (4) Dr. Herman Rosenblum, (5) Dr. P. B. Hamilton, (6) Dr. D. J. King, (7) Dr. D. S. Grice, (8) Dr. H. M. Brodar, (9) Dr. C. C. Muehe, and (10) Dr. A. R. Shands, Jr.

After the scientific session, there was a business meeting followed by a dinner at the du Pont Country Club.

MARSHALL BERGEN, M.D.

Publications Chairman

Obituaries • • •

DR. CHARLES FREDERICK BECKER

Dr. Charles Frederick Becker, a Camden general practitioner, died suddenly at his home on October 28, 1958. A graduate of the Jefferson Medical College, class of 1953, Dr. Becker was on the staff of the Camden General Hospital. Dr. Becker was born in Camden in 1925. A veteran of World War II, he was active in Legion and county medical affairs.

DR. JOHN R. CREMENS

Dr. John Francis Cremens died suddenly at the age of 70 on November 13, 1958. Born in Boston, he was graduated in 1916 from the University of Georgia Medical School. He then became a medical officer in the Navy, serving with distinction from 1917 to 1923. His last naval assignment, to the depot at Lake Denmark, N. J., acquainted him with out state and he elected to remain here the rest of his long and useful life. He opened an office for general practice in Paterson. He became surgeon to the Fire Department. He was a busy family doctor, interested in all phases of medicine. Dr. Cremens was also a civic leader, active in the affairs of the Elks and of the Knights of Columbus.

DR. DONALD V. LEDDY

At the untimely age of 35, Dr. Donald V. Leddy, a promising young Bergen County psychiatrist, died on November 6, 1958, after a brief illness. Born in New York City, Donald Leddy was graduated in 1948 from the medical school of Georgetown University. He interned at the Walter Reed Medical Center in Washington and then went on active duty in the Army. He served overseas and gradually rose from captain to lieutenant colonel. In the meantime he was doing graduate work in psychiatry at Georgetown and at the Postgraduate Center in Washington and, in 1955, was certified as a diplomate in psychiatry. He then entered private practice in Ridgewood and became affiliated with the Valley Hospital in Ridgewood and with the St. Joseph Hospital in Paterson.

DR. IRVING K. LOVETT

Dr. Irving Kennedy Lovett died at his home in Red Bank on November 2, 1958 after a brief illness. He was born in Little Silver in 1890 and received his M.D. degree from Johns Hopkins in 1916. He was a captain in the Medical Corps in 1917 and 1918 and then returned to his native county to practice. Dr. Lovett served the people of the shore area for forty years as general practitioner and family doctor. He was on the staff of the Monmouth Medical Center and was also affiliated with the Riverview Hospital in Red Bank.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Atomic Age and Our Biologic Future. By H. V. Bronsted. New York, 1958. The Philosophical Library. Pp. 80. ($2.75)

Our Nuclear Adventure. By D. G. Arnott. New York, 1958. The Philosophical Library. Pp. 168. ($6.00)

As we have just moved from the atomic age into the space age, it is not surprising that we are getting many books on the medical effects of radiation and space travel. These are two British books, printed on a rather poor quality paper, and —considering their small size—somewhat overpriced.

Bronsted explains radiation-produced mutation in words of one syllable. There is also a good explanation of the "isotope" concept. He discusses the dangers of radiation in terms of its long range effect on our children's children. Arnott's book covers more territory since it includes a good deal of basic information on atoms, energy, radiation, and nuclear power as well as a lucid discussion of the biologic effects of radiation. Both books are solid in content. Neither author is a physician. We cannot blame the publishers for this, because few M.D.s have shown much interest in, or grasp of these problems. Surely every physician now has a duty to learn more about the effect of radiation and ionization on our biologic future. And these two books will help him acquire the basis for that additional learning.

HERBERT BOEHM, M.D.

Clinical Obstetrics and Gynecology. 1. Medical Problems in Pregnancy. 2. Management of Endocrine Problems. Curtis J. Lund, M.D. and Allan C. Barnes, M.D. New York, 1958. Hoeber. Pp. 286. ($4.50)

Something new has been added to the literature of clinical medicine. This is the first of a series of monographs covering compact clinical phases of obstetrics and gynecology. Each volume will contain one item in each of these subspecialties. The material in volume 1 is indicated in the caption above. The plan is to offer four issues a year. The aim is to bridge the gap between the full-length, broad-coverage book, and the prematurely reported, unseasoned material that often finds its way into journals.

The first half of volume one covers such complications of pregnancy as hepatitis, thyroid disease, anemia, diabetes, heart disease, urinary infection, poliomyelitis, tuberculosis and multiple sclerosis. The second half discusses diagnostic aids in endocrinology, menstrual manifestations of endocrinopathies, and aspects of endocrinology related to gynecology. Each chapter is written by an expert. If the rest of the series continues the high standards of volume 1, the gynecologists, obstetricians and general practitioners of the country will have reason for gratitude at this kind of practical work being placed so readily at their disposal.

VICTOR HUBERMAN, M.D.

Negroes and Medicine. By D. C. Reitzes. Cambridge 1958, Harvard University Press for The Commonwealth Fund. Pp. 400 with 117 tables. ($7.00)

It has always been our boast that medicine dispenses its peculiar benefits to all regardless of race, religion or national origin. And it does seem likely that, in the north, Negro patients do not receive any lower grade of treatment from a given physician than do his white patients. But Negroes themselves feel that there should be more Negro physicians in our democracy. Negroes constitute 10 per cent of the population but only 2¼ per cent of our physicians. The author of this book agrees with this contention and says, indeed, that the quality of the health care provided to the Negro population is directly related to the number and quality of Negro physicians available. This, it seems to me, is not only a questionable doctrine, but a mischievous one. It accepts the concept of a quota system.

In the past decade the number of Negro medical students in predominantly white schools has soared from 93 to 236 and the number of white schools accepting Negroes has jumped from 20 to 48. This book is a study of the status of Negro physicians in 14 communities, 3 of them in the deep South. For each area, the author gives the historical background and current pattern of Negro physicians in private practice, in clinics and in hospitals. As an "index of integration," he calculates the ratio of Negro physicians affiliated with "white hospitals"—a ratio which varies from 0 in the South to 71 per cent for Brooklyn and 82 for Gary, Indiana.

The book is heavy with tables (117 of them!) but its solemnity of tone is lightened by numerous anecdotes and case studies, some of them highly dramatic. On the whole, this is a solid contribution to one of our nation's major sources of embarrassment. If we are a bit ashamed of the islands of bigotry still existing in our profession in our part of the country, we can also feel proud of the conspicuous progress made towards that benign color blindness which bestows on each human being the dignity of being judged on his own merits only.

HENRY A. DAVIDSON, M.D.

Foundations of Neuropsychiatry. By Stanley Cobb, M.D. Baltimore 1958. Williams and Wilkins. Ed. 6. Pp. 313. ($5.00)

For more than 20 years this book (originally published as a *Preface to Nervous Diseases*) has served as an underpinning in neurology and neurophysiology for medical students and general practitioners. Dr. Cobb wants to keep intimate the marriage between neurology and psychiatry. He does so by having psychiatry conform to the patterns of neurology. Actually only 50 pages are devoted to what is conventionally considered the scope of psychiatry, and even here the approach is physiologic and neurologic. Thus, the chapters on psychiatry deal with learning, consciousness, reason, drives, energy, attention and the like. In such areas as delusions, obsessions, and anxiety, the material is treated only descriptively without interpretation. There is some discussion of emotion, but only in terms of physiologic changes. This new edition includes material on feed-back mechanisms, pain, and neurochemistry (it is significant that Dr. Cobb calls it neurochemistry not psychopharmacology). It is a solid and sober contribution to the foundations of neurology.

ABRAHAM LEFF, M.D.

Infectious Diseases of Children. By Saul Krugman, M.D. and Robert Ward, M.D. St. Louis 1958, Mosby. Pp. 340. ($10.00)

Most infectious diseases occur in childhood. Some of the infections have become less common during the past quarter of a century. Included in this diminishing group are meningitis, pneumonia, erysipelas, diphtheria, poliomyelitis and mastoiditis. But the common cold, measles, mumps and chicken pox are still disabling millions of children. And virus diseases, perhaps, are getting more common—or at least are more commonly labelled. Krugman and Ward, in this compact monograph, discuss the traditional exanthematous diseases and then review viral involvements, diphtheria, influenza, meningitis, rickettsial infections, and the various infestations, as well as influenza, tetanus and toxoplasmosis. The diseases are treated in standardized fashion—etiology, pathology, manifestations, diagnosis, prognosis, epidemiology, prevention and treatment. Illustrations are scanty but good. Each chapter is enriched by a usable bibliography. The chapter on communicable disease control is something that every doctor ought to know. A penultimate chapter on differential diagnosis is a valuable *vade mecum*. The writing style is dry, but the content is solid and the text is thoroughly up to date.

RALPH NEIL SHAPIRO, M.D.

Modern Treatment Yearbook for 1958. Edited by Sir Cecil Wakeley. London 1958. Balliere, Tindall and Cox. Published in U.S.A. through Williams and Wilkins, Baltimore. Pp. 312. ($6.00)

The differences between British and American practice are highlighted by this book which, in spite of its title, emphasizes pathology and diagnosis more than treatment. There are chapters on the management of old people, the handling of psychogenic pains, the treatment of bronchitis, the abuse of ear drops, the human breast and renal aspects of diabetes. In all there are 31 chapters on as many topics. Some of the chapters (the last one on cardiac conditions in infancy, for instance) have nothing in them about treatment. For bronchitis, the author recommends "draughts" of sodium chloride and sodium bicarbonate in hot water. In many places proprietary drugs (unknown to American practice) are recommended. For aches and pains of psychogenic origin, the author suggests kindness, firmness, and tranquilizing drugs. The book is livened by advertisments in the end pages. Among the items so advertised are insurance, private nursing homes in London, a Pilsner Beer (it says it is a fine tonic), the Milton Method of keeping baby's bottle sterilized, and Dr. Collis Browne's Original and Genuine Chlorodyne. ("Always insist on Dr. Collis Browne's" the man says).

HERBERT BOEHM, M.D.

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† Obituary
e—Editorial
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TUBERCULOSIS *Abstracts*

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Current Trends in Tuberculosis

Donald A. Trauger, Division of Social Research, National Tuberculosis Association, August, 1958.

While tuberculosis death rates in the United States have continued to decrease in the last few years, technical and theoretical advances have led to radically altered ideas about the nature of the tuberculosis control problem.

It is continually more apparent that the tuberculosis problem of tomorrow is the residue of yesterday's problem. Cases developing currently appear to be the results of old infections rather than new. It is now believed that the reservoir of infection is decreasing. In this sense, tuberculosis appears to be under control.

From another viewpoint, the road to eradication of tuberculosis is not clearly marked. Although the new chemotherapy is far superior to treatment of the past, it is increasingly clear that we do not possess a certain and permanent cure for tuberculosis. Furthermore, we do not possess an adequate immunizing agent. One of the glaring omissions from what is needed to eradicate tuberculosis is knowledge of specific ways to eliminate infection, or to eliminate the consequences of infection.

Our control programs contain substantial loopholes and are subject to new threats. During 1956, at least 3,000 persons died of tuberculosis who had not previously been reported to the health department. Each day, new x-ray evidence suggests that many others have survived a bout of active tuberculosis without public health supervision. There is some tendency to relax our efforts at control and divert our attention and efforts in other directions. Finally, new knowledge of ionizing radiation has ended the era in which these rays could be used without regard to their possible consequences. It is now necessary to ask in each instance, "Are the risks of omitting a chest x-ray of this person greater than the risks of giving it?" If the person reacts to tuberculin it would seem the answer is affirmative.

● Where do we stand in tuberculosis control? Death rates are no longer an adequate measure and other data are incomplete but it is evident that in spite of progress much remains to be done.

Current Situation

What is the present situation and what are the current trends? It is significant that the death rate from tuberculosis is no longer regarded as an adequate measure of the extent of the tuberculosis problem. In 1900 the death rate was 194 per 100,000 population. In 1956 the tuberculosis death rate had dropped to 8.4 per 100,000 and the average age of persons dying of tuberculosis was increased to 58.4. The decline in case rates has not paralleled the decline in death rates. When only new active cases are considered, the rate is about five times the death rate. In 1956, 68,866 cases were reported as active or probably active. Precise data are not available but the changing relationship of cases to deaths suggests that a disease which once killed half the people it attacked, now kills only one out of five.

It is currently estimated that there are about 250,000 active cases of tuberculosis in the United States and that 100,000 of these are unknown to health officials and presumably not receiving medical attention. Of the 150,000 known cases, probably more are receiving effective treatment than ever before. While there have been substantial drops in the occupancy of beds in tuberculosis hospitals, the number of people receiving some period of hospitalization is probably greater than ever. There is little question that the number of patients receiving treatment as out-patients is on the increase. Unfortunately, there is little question that some cases are receiving little or no medical supervision. One study of active patients outside hospitals in 1955 showed that half of them had had no examination of sputum within

six months of the study. At the same time, and often in the same areas, there is concern for enactment of new legislation and the provision of new facilities for the forcible detention and isolation of tuberculous persons who refuse to take appropriate steps to prevent spread of their infection to others.

Tuberculosis is still a costly disease. It has been estimated that the total cost for 1956 was in excess of $725,000,000. The bulk of the money is for hospitalization and rehabilitation and for compensation. Hidden costs such as lost earnings are not included.

Treatment

Data on the adequacy of treatment are not available, but a recent report of the situation five years after beginning treatment of a group of cases with modern therapy is significant. Twenty per cent of the original group were dead and about two-thirds of these died of tuberculosis. Of those alive, one-fifth still had active tuberculosis. Treatment in the complete sense is still not available to many patients. Rehabilitation services are not readily available in some places and in some other instances available services are not designed to meet the needs of tuberculosis patients of today.

In the field of case finding, accurate data are not available, but screening x-rays of apparently healthy people occur at the level of 20 million a year. In addition, a considerable number of children are tuberculin tested annually. Few areas publish data on the extent of their search for tuberculosis among contacts of persons with tuberculosis, known or suspected. It is believed that the performance is spotty and in certain areas the responsibility for the performance of these functions has not been accepted as a tax-supported public health responsibility.

The fate of the presently infected population is one of the greatest enigmas in tuberculosis. How many will develop tuberculosis, how do we know who they are and what can we do to prevent the development of disease? There is hope, but no certainty that research and experimentation will provide a vaccine that produces more natural immunity or that an effective prophylaxis can be developed to prevent progression of existing infections. Possibly, other non-specific factors may develop or continue to increase host-resistance. Unless one or more of these possibilities actually develops, experience of the past few years suggests that the tuberculosis already seeded in millions of our friends and neighbors will ripen into clinically recognizable and communicable tuberculosis at rates which twenty years hence will still be at least half as great as the present rate.

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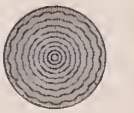
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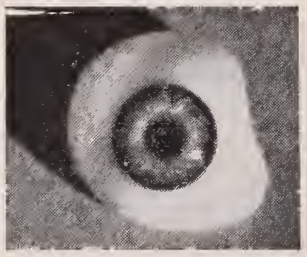
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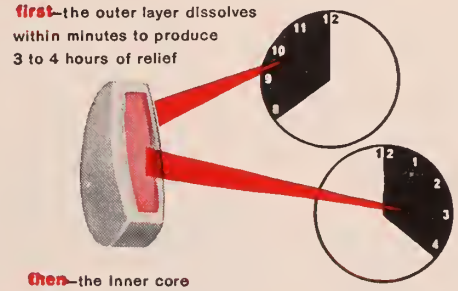
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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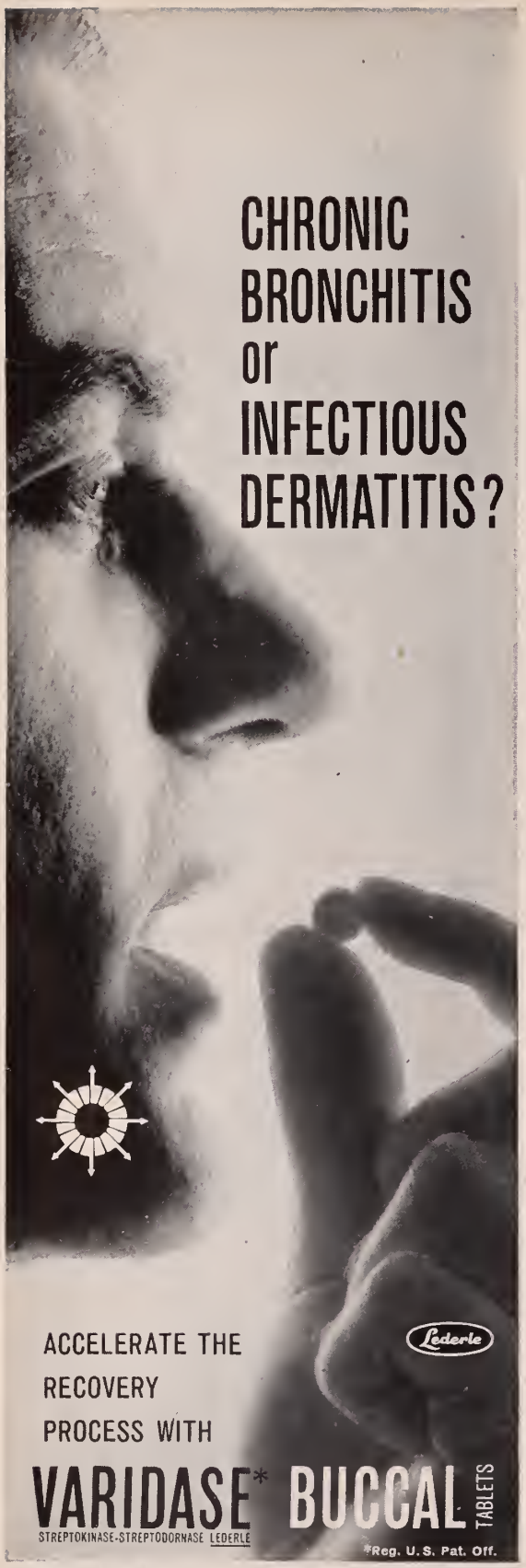
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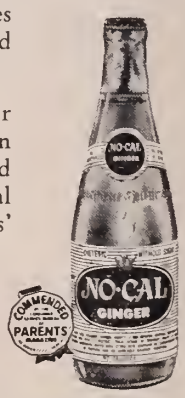


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The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 15F

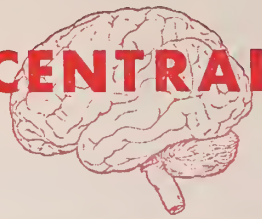
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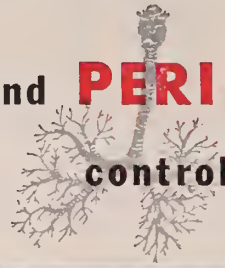
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Ammonium chloride	70.0 mg.
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*Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. *23*:41 (Jan.) 1958.

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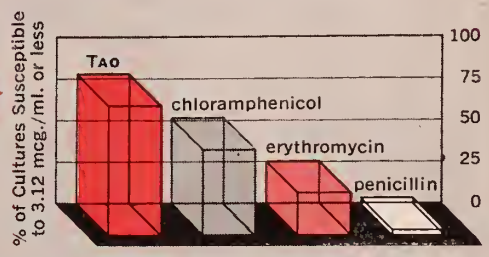
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CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2]. . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated. . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

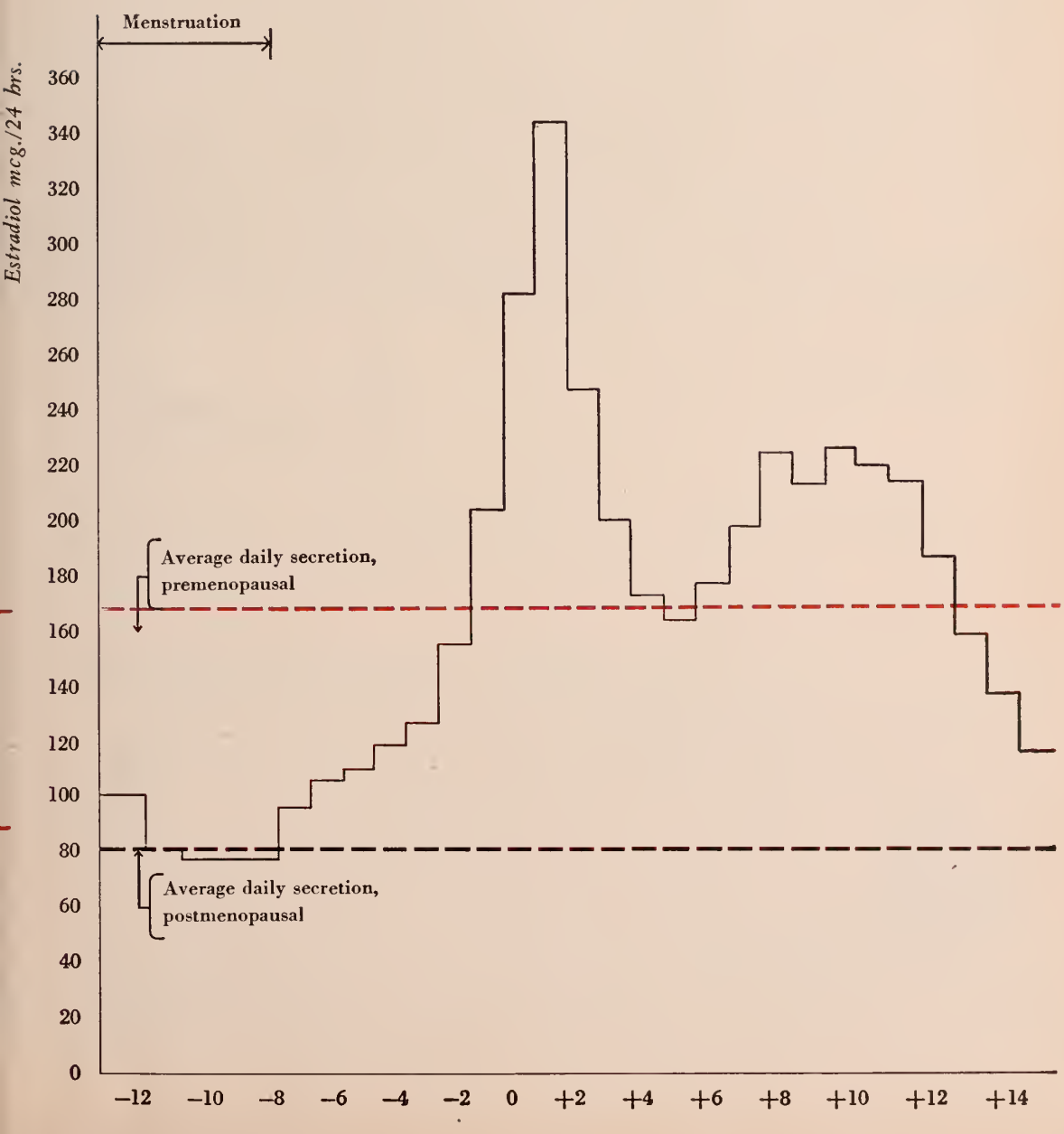
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

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(calculated from average 24-hour urinary excretion
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REFERENCES:

1. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958.
2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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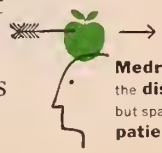
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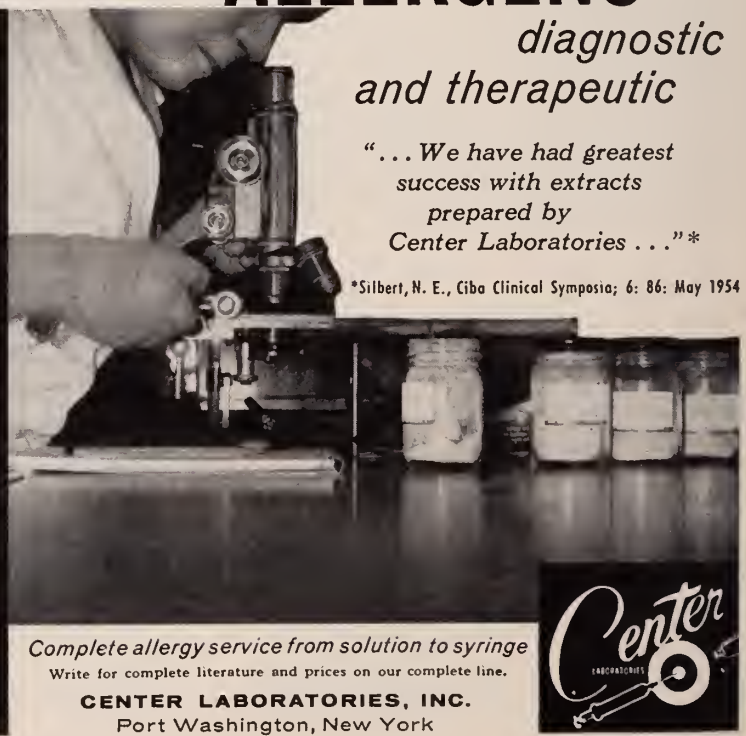
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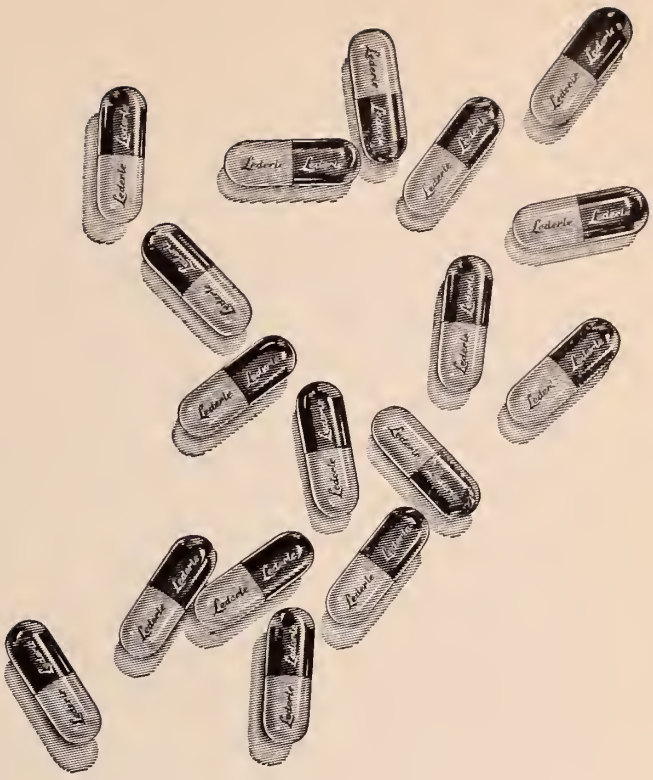
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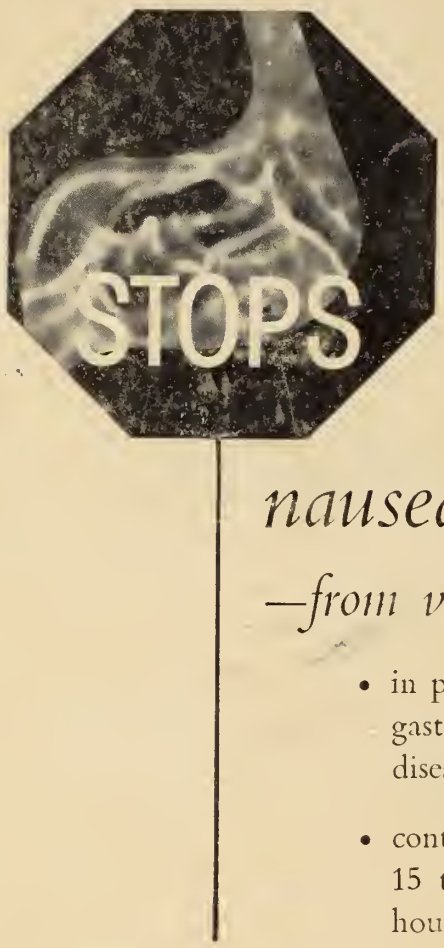
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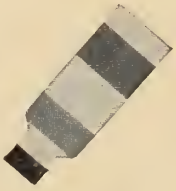
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